

Health Coverage Appeal Information Packet

Carefully read the information in this packet and keep it for future reference. It has important information about how to appeal decisions Blue Cross Blue Shield of Arizona makes about your health coverage.

- **Obtaining Information About the Health Coverage Appeals Process¹**

- **Standardized Forms and Consumer Assistance from the Department of Insurance**

- **Help in Filing an Appeal**

Blue Cross Blue Shield of Arizona (BCBSAZ²) must send you a copy of this information packet when you first receive your policy and within five (5) business days after it receives your request for a Level 1 appeal. When your insurance coverage is renewed, BCBSAZ must also send you a separate statement to remind you that you can request another copy of this packet. BCBSAZ will also send a copy of this packet to you or your treating provider any time you ask. Call BCBSAZ's automated supply line at (602) 995-6960 to ask for another copy of the packet.

At the back of this packet, you will find forms you can use for your appeal. The Arizona Department of Insurance (ADOI) developed these forms to help people who want to file a health care appeal. You are not required to use these forms. BCBSAZ cannot reject your appeal if you do not use them. If you need help in filing an appeal, or you have questions about the appeals process, you may call the ADOI's Consumer Assistance Office at (602) 364-2499 or (800) 325-2548 or call BCBSAZ at (602) 864-4400 or (800) 232-2345.

How to Know When You Can Appeal

When BCBSAZ does not authorize or approve a service not yet provided or does not pay for a claim for services already provided, it must notify you of your right to appeal that decision. Your notice may come directly from BCBSAZ or through your treating provider.

Decisions You Can Appeal

You can appeal the following decisions:

1. BCBSAZ does not approve a service that you have or your treating provider has requested, but that you have not yet received.
2. BCBSAZ does not pay for a service that you have already received.
3. BCBSAZ does not authorize a service or pay for a claim because it is not "medically necessary".
4. BCBSAZ does not authorize a service or pay for a claim because it is not covered under your insurance policy, and you believe it is covered.
5. BCBSAZ does not authorize a referral to a specialist.
6. Where preauthorization for a service is required by your benefit plan, BCBSAZ does not approve or deny your preauthorization request within ten business days.

Decisions You Cannot Appeal

Although the items listed below are not appealable under state law, you and/or your authorized representative may have the right to appeal some of the following types of decisions under federal law or submit a grievance through the BCBSAZ Grievance process. Please consult the section entitled “Additional Federal Rights for Group Plans” for additional important information regarding your appeal rights under federal law and/or the section of the Benefit Plan Booklet entitled “Grievance Process,” which explains your rights to submit a grievance.

Under Arizona law, you cannot appeal the following decisions:

1. You disagree with BCBSAZ’s decision as to the amount of the BCBSAZ allowed amount.
2. You disagree with how BCBSAZ is coordinating benefits when you have health insurance with more than one insurer.
3. You disagree with how BCBSAZ has applied your claims to your plan deductible.
4. You disagree with the amount of coinsurance or copayments that you paid.
5. You disagree with BCBSAZ’s decision regarding a possible nondisclosure.
6. You are dissatisfied with any rate increases you may receive under your insurance policy.
7. You believe BCBSAZ has violated any other parts of the Arizona Insurance Code.

For those matters that are not appealable, you and/or your provider may submit a grievance to BCBSAZ in accordance with BCBSAZ’s Grievance Process, which is described in your benefit plan booklet. If you disagree with a decision that is not appealable, you may also file a complaint with the Arizona Department of Insurance, Consumer Affairs Division, 2910 N. 44th St., Second Floor, Phoenix, AZ 85018.

Additional Federal Rights for Group Plans (Excluding Governmental Plans and Church Plans)

Levels 2 and 3 of Expedited Appeals and Standard Appeals and Level 2 of the Grievance Process are voluntary. If you choose not to participate in Levels 2 or 3 of the Appeal Process or Level 2 of the Grievance Process, BCBSAZ will waive its right to assert that you have failed to exhaust administrative remedies. Any statute of limitations defense or other defenses based on timeliness will be stopped while your voluntary appeal or grievance is pending.

No fees or costs may be imposed upon you as part of any voluntary level of appeal or grievance. Before deciding to submit your claim to Levels 2 & 3, you also have the right to ask BCBSAZ for information about: (1) the rules for Levels 2 and 3, (2) your right to representation at these levels, (3) the process for selecting the decision maker, and (4) circumstances that may affect the impartiality of the decision maker, if any. If you want this information, please call or write to the following address and telephone number:

Medical Appeals and Grievances Coordinator
Formal Appeal A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

You may submit written comments, documents, or other information in support of your appeal or grievance, and you will have access to all documents that are relevant to your claim. Your appeal or grievance will be conducted by a person different from the person who made the initial decision. No deference will be afforded to the initial determination.

If your appeal involves a medical judgment question, BCBSAZ will consult with an appropriately qualified health care practitioner with training and experience in the field of medicine involved. An appropriately trained health care practitioner means a physician trained in the general practice of medicine who will consult with a specialist if deemed necessary in his or her professional judgment. If a health care professional was consulted for the initial determination, a different health care professional will be consulted on appeal. Upon request, BCBSAZ will provide you with the identification of any medical expert whose advice was obtained on behalf of the plan in connection with your appeal.

These Appeal & Grievance rights are in addition to your rights to challenge BCBSAZ’s decision in court, including, but not limited to bringing legal action under Section 502(a) of the Employee Retirement Income Security Act of 1974 (ERISA). You and your ERISA plan may have other voluntary alternative dispute resolution options in addition to the Appeals and Grievance Processes described in your benefit plan booklet, such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office. You may also be able to obtain information from your group benefits administrator.

Who Can File An Appeal

Either you or your treating provider can file an appeal on your behalf. At the end of this packet is a form that you may use for filing your appeal. You and your treating provider are not required to use this form and may send BCBSAZ a letter with the same information.

Description of the Appeals Process

If you wish to appeal BCBSAZ’s initial decision, you have the right to have your claim reviewed under three different levels of appeal that BCBSAZ must offer you under either federal law or Arizona state law.

There are two types of appeals: (1) expedited appeal for urgent matters, and (2) standard appeal. Each type of appeal has three levels. The appeals operate in a similar fashion, except that expedited appeals are processed much faster because of the patient’s condition.

	Expedited Appeals (for urgently needed services you have not yet received)	Standard Appeals (for non-urgent services or denied claims)
Level 1	Expedited Medical Review	Informal Reconsideration
Level 2	Expedited Appeal	Formal Appeal
Level 3	Expedited External Independent Review	External Independent Review

- Level 1 is an appeal required to be offered under the federal Employee Retirement Income Security Act (“ERISA”) law and Arizona state law.
- Levels 2 & 3 are appeals required to be offered under Arizona state law.

Expedited Appeal Process For Urgently Needed Services Not Yet Provided

Level 1: Expedited Medical Review

Your request: You may obtain Expedited Medical Review of your denied request for a service that has not already been provided if

- BCBSAZ or Biodyne (the behavioral health provider) denied your request for a covered service, and
- Your treating provider certifies, either orally or in writing, that application of the time periods for a standard appeal could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request. BCBSAZ cannot challenge your treating provider’s opinion or certification.

You or your treating provider may submit to BCBSAZ written comments, documents, records or other information in support of your expedited appeal. Expedited appeals may be requested orally or in writing by calling or writing to:

Medical Appeals and Grievances Specialist – Medical Appeals and Grievances A116
 BCBSAZ
 P.O. Box 13466
 Phoenix, AZ 85002-3466
 Fax: (602) 544-5601
 Phone: (602) 544-4938 or (866) 595-5998

For Behavioral Health services requested through Biodyne, you must call or write to:

Director of Clinical Services – Appeals
MBH/Arizona Biodyne
2301 West Dunlap, Suite 210
Phoenix, AZ, 85021
Phone: (800) 224-2125 ext. 82166
Fax: (602) 331-1184

BCBSAZ or Biodyne’s decision: BCBSAZ or Biodyne must notify you of its decision as soon as possible in accordance with medical exigencies, but no later than one business day after it receives your appeal request. In the event of a three or four day holiday weekend, BCBSAZ or Biodyne will notify you of its decision as soon as possible in accordance with medical exigencies, but no later than 72 hours after we receive your appeal request. Within this required time, we must call and notify you and your treating provider of our decision, and fax or mail to you our decision in writing.

BCBSAZ or Biodyne will inform you in writing whether it has changed its decision to authorize your request or will uphold its original decision to deny your request. The written decision will: explain the specific reason for the determination; reference specific plan provisions on which the determination is based; contain a statement informing you of your right, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to your appeal; describe any voluntary appeal procedures offered by the plan and your right to request information about such procedures; state that you have a right to request a copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the determination, free of charge; state that you have the right to request an explanation of the scientific or clinical judgment for a determination that a service is not medically necessary or investigational, free of charge; state that you have the right to request the identification of any medical or vocational expert BCBSAZ or Biodyne consulted in connection with the determination; and if applicable, a statement regarding your right to bring action under Section 502 (a) of ERISA.

If BCBSAZ or Biodyne denies your request: You may immediately appeal to Level 2.

If BCBSAZ or Biodyne grants your request: BCBSAZ or Biodyne will authorize the service and the appeal is over.

If BCBSAZ refers your case to Level 3: If you are not covered by an employer plan subject to federal law, BCBSAZ may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3.

Level 2: Expedited Appeal

- **Your request:** If BCBSAZ or Biodyne denies your request at Level 1, after you receive the Level 1 denial, your treating provider must immediately send us a written request to tell us you are appealing to Level 2. In that written request, your treating provider must certify and provide supporting documentation that the time required to process your request through the Formal Appeal process is likely to cause a significant negative change in your medical condition. At the end of this packet is a form that your provider may use for this purpose. Your treating provider could also send a letter with the same information.
- To help your appeal, your provider should also send us any additional information that was not previously supplied to show why you need the requested service. The provider must send the request, certification and supporting documentation to:

Medical Appeals and Grievances Coordinator – Expedited Appeal A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

BCBSAZ’s decision: BCBSAZ has three (3) business days after we receive the request to make our decision.

If BCBSAZ denies your request: You may immediately appeal to Level 3.

If BCBSAZ grants your request: BCBSAZ will authorize the service and the appeal is over.

If BCBSAZ refers your case to Level 3: BCBSAZ may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: Expedited External Independent Review³

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have **only five (5) business days** after you receive BCBSAZ's Level 2 decision to send BCBSAZ your **written** request for Expedited External Independent Review. Send your request and any additional supporting information to:

Medical Appeals and Grievances Coordinator – Expedited External Review A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

1. Medical necessity

These are cases where BCBSAZ has decided not to authorize or approve a service not yet received because it has been determined the services you or your treating provider are asking for are not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an outside independent review organization ("IRO") that is procured by the Arizona Department of Insurance³. The IRO provider must be a provider who typically manages the condition under review.

2. Contract coverage

These are cases where BCBSAZ has denied coverage because the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance is the independent reviewer⁵.

Medical Necessity Cases

Within one (1) business day of receiving your request, BCBSAZ must:

1. Mail a written acknowledgement of the request to the Insurance Director/IRO³, you, and your treating provider.
2. Send the Insurance Director/IRO³: the request for review; benefit plan booklet; all medical records and supporting documentation BCBSAZ used to render its decision; a summary of the applicable issues including a statement of BCBSAZ's decision; the criteria used and clinical reasons for the decision; and the relevant portions of BCBSAZ's utilization review guidelines. BCBSAZ must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within two (2) business days of receiving this information from BCBSAZ, the Insurance Director must send all the submitted information to an external IRO.

Within five (5) business days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within one (1) business day of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to you, your treating provider, and BCBSAZ.

Self-funded Group Plans

Within five (5) business days of receiving this information from BCBSAZ, the IRO must make a decision and send the decision to BCBSAZ.

Within one (1) business day of receiving the IRO's decision, BCBSAZ must mail a notice of the decision to you and your treating provider.

The decision (medical necessity): If the IRO decides that BCBSAZ should authorize or approve the service, BCBSAZ must authorize the service. The IRO's decision is a final administrative decision, subject to judicial review as set forth in A.R.S. §20-2537.⁴

Contract Coverage Cases

Within one (1) business day of receiving your request, BCBSAZ must:

1. Mail a written acknowledgement of your request to the Insurance Director/IRO³, you, and your treating provider.
2. Send the Insurance Director/IRO³: the request for review, your benefit plan booklet, all medical records and supporting documentation BCBSAZ used to render its decision, a summary of the applicable issues including a statement of BCBSAZ's decision, the criteria used, and any clinical reasons for the decision and the relevant portions of BCBSAZ's utilization review guidelines.

Within two (2) business days of receiving this information, the Insurance Director/IRO³ must determine if the service is covered, issue a decision, and send a notice to you, your treating provider, and BCBSAZ. (For self-funded groups, the IRO will send this information to BCBSAZ, which will then send it to you and your treating provider within one (1) business day.)

Referral to the IRO for contract coverage cases³: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have five (5) business days to make a decision and send it to the Insurance Director. The Insurance Director will have one (1) business day after receiving the IRO's decision to send the decision to you, your treating provider, and BCBSAZ.

The decision (contract coverage)⁵: If you disagree with Insurance Director's final decision on a contract coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If BCBSAZ disagrees with the Director's final decision, it may also request a hearing before OAH. In this situation, BCBSAZ must authorize the service while the OAH hearing is pending. A hearing must be requested within 30 days of receiving the Director's decision. OAH must promptly schedule and complete a hearing for appeals from expedited Level 3 decisions.

Standard Appeal Process for Non-urgent Requested Services and Denied Claims

Level 1: Informal Reconsideration

Your request: You may obtain Informal Reconsideration if BCBSAZ or Biodyne does not pay for services already provided or denies authorization or approval for services not yet provided if:

- You have coverage with BCBSAZ,
- BCBSAZ or Biodyne denied your claim for services already provided or your request for authorization or approval of a service yet provided,
- You do not qualify for an expedited appeal, and
- You or your treating provider asks for Informal Reconsideration within two (2) years of the date BCBSAZ first denies the requested service or claim by calling, writing, or faxing your request to:

A. For Denials of Authorizations or Approvals for Services That Have Not Yet Been Provided

Medical Appeals and Grievances Specialist – Medical Appeals and Grievances A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

B. For Denials of Claims for Services Already Provided

Medical Appeals and Grievances Specialist – Medical Appeals and Grievances A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

C. For Denials of Authorizations or Approvals for Services That Have Not Yet Been Provided or Denials of Claims for Services provided through Biodyne

Director of Clinical Services – Appeals
MBH/Arizona Biodyne
2301 West Dunlap, Suite 210
Phoenix, AZ, 85021
Phone: (800) 224-2125 ext. 82166
Fax: (602) 331-1184

BCBSAZ and Biodyne’s acknowledgement: BCBSAZ and Biodyne have five (5) business days after we receive your request for Informal Reconsideration (“the receipt date”) to send you and your treating provider a notice that we received your request.

BCBSAZ and Biodyne’s decision: BCBSAZ or Biodyne have 30 days after the receipt date to decide whether we should change our decision and authorize your requested service or pay your claim. Within that same 30 days, we must send you and your treating provider our written decision.

BCBSAZ or Biodyne will inform you in writing whether it has changed its decision to authorize your request or will uphold its original decision to deny your request. The written decision will: explain the specific reason for the determination; reference specific plan provisions on which the determination is based; contain a statement informing you of your right, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to your appeal; describe any voluntary appeal procedures offered by the plan and your right to request information about such procedures; state that you have a right to request a copy free of charge of any internal rule, guideline, protocol or other similar criterion relied upon in making the determination; state that you have the right to request an explanation free of charge of the scientific or clinical judgment for a determination that a service is not medically necessary or investigational; state that you have the right to request the identification of any medical or vocational expert BCBSAZ or Biodyne consulted in connection with the determination; and if applicable, a statement regarding your right to bring action under Section 502 (a) of ERISA.

If BCBSAZ or Biodyne denies your request: You have 60 days to appeal to Level 2.

If BCBSAZ or Biodyne grants your request: BCBSAZ or Biodyne will authorize the service or pay the claim and the appeal is over.

If BCBSAZ refers your case to Level 3: BCBSAZ may decide to skip Level 1 and Level 2 and send your case straight to an independent reviewer at Level 3. (Level 1 cannot be skipped if you are covered by an employer group plan subject to federal law).

Level 2: Formal Appeal

Your request: You may request Formal Appeal if BCBSAZ or Biodyne denies your request at Level 1. After you receive the Level 1 denial, you or your treating provider must send a written request within 60 days to tell BCBSAZ you are appealing to Level 2. To help BCBSAZ make a decision on your appeal, you or your provider should also send any additional information not previously sent to show why the requested service should be authorized or the claim paid. You must send your appeal request and information to:

Medical Appeals and Grievances Coordinator – Formal Appeal A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

BCBSAZ’s acknowledgement: BCBSAZ has five (5) business days after receipt of your request for Formal Appeal (“the receipt date”) to send you and your treating provider a notice that your request was received.

BCBSAZ’s decision: For a denied authorization or approval of service that you have not yet received, BCBSAZ has 30 days after the receipt date to decide whether we should change our decision and authorize your requested service. For denied claims, BCBSAZ has 60 days to decide whether the decision should be changed and pay your claim. BCBSAZ will send you and your treating provider its decision in writing. The written decision must explain the reasons for the decision and tell you the documents on which the decision was based.

If BCBSAZ denies your request or claim: You have 30 days to appeal to Level 3.

If BCBSAZ grants your request: BCBSAZ will authorize the service or pay the claim and the appeal is over.

If BCBSAZ refers your case to Level 3: BCBSAZ may decide to skip Level 2 and send your case straight to an independent reviewer at Level 3.

Level 3: External Independent Review³

Your request: You may appeal to Level 3 only after you have appealed through Levels 1 and 2. You have **30 days** after you receive the Level 2 decision to send BCBSAZ your written request for External Independent Review. You must send your request and any more supporting information to:

Medical Appeals and Grievances Coordinator – External Review A116
BCBSAZ
P.O. Box 13466
Phoenix, AZ 85002-3466
Fax: (602) 544-5601
Phone: (602) 544-4938 or (866) 595-5998

Neither you nor your treating provider is responsible for the cost of any external independent review.

The process: There are two types of Level 3 appeals, depending on the issues in your case:

1. Medical necessity

These are cases where BCBSAZ has decided not to authorize or approve a service not yet received or pay a claim for services already received because it has been determined the services you or your treating provider are asking for are not medically necessary to treat your condition. For medical necessity cases, the independent reviewer is a provider retained by an IRO, procured by the Arizona Department of Insurance³, and not connected with BCBSAZ. For medical necessity cases, the provider must be a provider who typically manages the condition under review.

2. Contract coverage

These are cases where BCBSAZ has denied coverage because the requested service is not covered under your insurance policy. For contract coverage cases, the Arizona Department of Insurance is the independent reviewer⁵.

Medical Necessity Cases

Within five (5) business days of receiving your request, BCBSAZ must:

1. Mail a written acknowledgement of the request to the Insurance Director/IRO³, you, and your treating provider.
2. Send the Insurance Director/IRO³: the request for review; your benefit plan booklet; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and clinical reasons for our decision; and the relevant portions of our utilization review guidelines. We must also include the name and credentials of the health care provider who reviewed and upheld the denial at the earlier appeal levels.

Within five (5) days of receiving the information, the Insurance Director must send all the submitted information to an external IRO.

Within 21 days of receiving the information the IRO must make a decision and send the decision to the Insurance Director.

Within five (5) business days of receiving the IRO's decision, the Insurance Director must mail a notice of the decision to you, your treating provider, and BCBSAZ.

Self-funded Group Plans

Within 21 days of receiving the information, the IRO must make a decision and send it to BCBSAZ.

Within five (5) business days of receiving the IRO's decision, BCBSAZ will mail the decision to you and your treating provider.

The decision (medical necessity): If the IRO decides that BCBSAZ should approve or authorize the service or pay the claim, the service must be authorized and/or the claim paid. The IRO's decision is a final administrative decision, subject to judicial review as set forth in A.R.S. §20-2537.⁴

Contract Coverage Cases

Within five (5) business days of receiving your request, BCBSAZ must:

1. Mail a written acknowledgement of your request to the Insurance Director/IRO³, you, and your treating provider.
2. Send the Insurance Director/IRO³: the request for review; your benefit plan booklet; all medical records and supporting documentation used to render our decision; a summary of the applicable issues including a statement of our decision; the criteria used and any clinical reasons for our decision; and the relevant portions of our utilization review guidelines.

Within 15 business days of receiving this information, the Insurance Director/IRO³ must determine if the service or claim is covered, issue a decision, and send a notice to you, your treating provider, and BCBSAZ. (For self-funded groups, the IRO will send this information to BCBSAZ, which will then send it to you and your treating provider within five (5) business days.) If the Director/IRO³ decides that BCBSAZ should authorize or approve the service or pay the claim, BCBSAZ must do so.

Referral to the IRO for contract coverage cases³: The Insurance Director is sometimes unable to determine issues of coverage. If this occurs, the Insurance Director will forward your case to an IRO. The IRO will have 21 days to make a decision and send it to the Insurance Director. The Insurance Director will have five (5) business days after receiving the IRO's decision to send the decision to you, your treating provider, and BCBSAZ.

The decision (contract coverage)⁵: If you disagree with the Insurance Director's final decision on a coverage issue, you may request a hearing with the Office of Administrative Hearings ("OAH"). If BCBSAZ disagrees with the Director's determination of coverage issues, we may also request a hearing at OAH. In this situation, BCBSAZ must authorize the service or pay the claim while the OAH hearing is pending. Hearings must be requested within 30 days of receiving the coverage issue determination. OAH has rules that govern the conduct of their hearing proceedings.

Obtaining Medical Records

Arizona law (A.R.S. §12-2293) permits you to ask for a copy of your medical records. Your request must be in writing and must specify who you want to receive the records. The health care provider who has your records will provide you or the person you specified with a copy of your records.

Designated Decision-Maker: If you have a designated health care decision-maker, that person must send a written request for access to copies of your medical records. The medical records must be provided to your health care decision-maker or a person designated in writing by your health care decision-maker unless you limit access to your medical records only to yourself or your health care decision-maker.

Confidentiality: Medical records disclosed under A.R.S. § 12-2293 remain confidential. If you participate in the appeal process, the relevant portions of your medical records may be disclosed only to people authorized to participate in the review process for the medical condition under review. These people may not disclose your medical information to any other people.

Documentation for an Appeal

If you decide to file an appeal, you must give BCBSAZ any material justification or documentation for the appeal at the time the appeal is filed. If you gather new information during the course of your appeal, you should give it to BCBSAZ as soon as you get it. You must also give BCBSAZ the address and phone number where you can be contacted. If the appeal is already at Level 3 and being administered through the Arizona Department of Insurance, you should also send the information to the ADOI.

The Role of the Insurance Director

Arizona law (A.R.S. §20-2533(F)) requires “any member who files a complaint with the Arizona Department of Insurance relating to an adverse decision to pursue the review process prescribed” by law. This means that, for appealable decisions, you must pursue the health care appeals process before the Insurance Director can investigate a complaint you may have against BCBSAZ based on the decision at issue in the appeal.

Arizona law requires the Director to:

1. Oversee the appeals process.
2. Maintain copies of each utilization review plan submitted by insurers.
3. Receive, process, and act on requests from an insurer for External Independent Review.
4. Enforce the decisions of insurers.
5. Review decisions of insurers.
6. Report to the Legislature.
7. Send, when necessary, a record of the proceedings of an appeal to Superior Court or to the Office of Administrative Hearings (OAH).
8. Issue a final administrative decision on coverage issues, including the notice of the right to request a hearing at OAH.

Receipt of Documents

Any written notice, acknowledgment, request, decision or other written document required to be mailed is deemed received by the person to whom the document is properly addressed on the fifth business day after being mailed. “Properly addressed” means your last known address.

¹ Arizona state insurance laws generally do not apply to self-funded group health plans that are governed by the Employment Retirement Income Security Act (ERISA). ERISA regulations do provide an appeal process that is comparable to the appeal process available under Arizona state insurance laws. This booklet covers both the Arizona and ERISA processes.

² In some cases, BCBSAZ may be acting as an administrator for a self-funded group health plan, and not in its capacity as an insurer.

³ The Arizona Department of Insurance (ADOI) does not have authority over Level 3 appeal decisions for certain group health plans that are ‘self-funded.’ BCBSAZ will refer all level 3 appeals (medical necessity & contract coverage) for members of those plans directly to an external independent review organization (IRO) without routing the appeal through ADOI. If you have a question about where your appeal is referred, please call the BCBSAZ Medical Appeals and Grievances Coordinator. For members of these group plans, references to the ADOI will mean the IRO.

⁴ Members of self-funded group plans do not have a right to judicial review under Arizona state law, but do (if not a member of a church or government plan) have the right to bring legal action under section 502(a) of ERISA.

⁵ Does not apply to self-funded group plans whose members’ appeals are submitted directly to the external independent review organization (IRO).

Health Coverage Appeal Request Form

You may use this form to tell BCBSAZ you want to appeal a denial decision.

Member Name _____ Member ID# _____

Name of representative pursuing appeal, if different from above _____

Mailing Address _____

Phone # _____

City _____ State _____ Zip Code _____

Type of Denial: Denied Claim Denied Service Not Yet Received

If you are appealing BCBSAZ's decision to deny a service you have not yet received, could a 30 to 60 day delay in receiving the service likely seriously jeopardize your life or health or your ability to regain maximum function or subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request? If your answer is "Yes," you may be entitled to an expedited appeal. Your treating provider must sign and send a certification and documentation supporting the need for an expedited appeal.

What decision are you appealing? _____

(Explain what you want BCBSAZ to authorize or pay for.)

Explain why you believe the claim or service should be covered:

(Attach additional sheets of paper, if needed.)

If you have questions about the appeals process or need help to prepare your Appeal, you may call the Arizona Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or BCBSAZ at (602) 864-4400 or (800) 232-2345.

Make sure to attach everything that shows why you believe BCBSAZ should cover your claim or authorize a service,

including: Medical records Supporting documentation (letter from your doctor, brochures, notes, receipts, etc.)

**Also attach the certification from your treating provider if you are seeking expedited review.

Medical Appeals and Grievances Department – Mail Stop A116
 BCBSAZ
 P.O. Box 13466
 Phoenix, AZ 85002-3466
 Fax: (602) 544-5601
 Phone: (602) 544-4938 or (866) 595-5998

Signature of insured or authorized representative _____ Date _____

Provider Certification Form for Expedited Medical Review



An Independent Licensee of the Blue Cross and Blue Shield Association

(You and your provider may use this form when requesting an expedited appeal.)

Is the appeal for a service that the patient has already received? Yes No

If "Yes," the patient must pursue the standard appeals process and cannot use the expedited appeals process.

If "No," continue with this form.

A patient who is denied authorization for a covered service not yet provided is entitled to an expedited appeal if the treating provider certifies and provides supporting documentation that the time period for the standard appeal process could seriously jeopardize your life or health or your ability to regain maximum function or would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

Provider Information

Treating Physician/Provider _____
Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

Patient Information

Member Name _____ Member ID# _____
Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

Insurer Information

Insurer Name _____
Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

What service denial is the patient appealing? _____

Explain why you believe the patient needs the requested service and why the time for the standard appeal process will harm the patient.

Attach additional sheets if needed and include: Medical records Supporting documentation

If you have questions about the appeals process or need help to prepare your Appeal, you may call the Arizona Department of Insurance Consumer Assistance number (602) 364-2499 or (800) 325-2548, or BCBSAZ at (602) 864-4400 or (800) 232-2345.

I certify, as the patient's treating provider, that delaying the patient's care for the time period needed for the informal reconsideration and formal appeal processes (about 60 days) is likely to seriously jeopardize the patient's life, health or ability to regain maximum function or subject the patient to severe pain that cannot be adequately managed with the care of treatment that is the subject of the request.

Provider's Signature _____ Date _____