curative

Curative Appeal Process

The enrollee, or person acting on the enrollee's behalf, and the provider of record have the right to appeal a clinical adverse determination orally or in writing. Please note, administrative denials do not have appeal rights. A physician who has not previously reviewed the case will make the appeal decision.

Curative offers 2 levels of appeal.

Our Internal Appeal Process - Level 1

For Texas Fully Insured plans: the appealing party must send us the appeal no later than 30 days after the date of the adverse determination letters.

For Georgia Fully Insured, Florida Fully Insured, Level Funded and Self-funded plans: the appealing party must send us the appeal no later than 180 days after the date of the adverse determination letters.

- **Written Appeal:** To submit a written appeal, fax the written appeal to the following fax number: Toll Free Fax #: 888-293-4075
- **Oral Appeal:** To file an oral appeal, call the following toll-free number: 855-414-1089

Types of Appeals:

- **Standard / Pre-Service Appeal:** An appeal that does not involve urgent care such as emergency care, life-threatening conditions, or continued hospitalization.
- **Expedited / Urgent Appeal:** An expedited appeal is available for emergency care denials, denials of continued stays for hospitalized enrollees and a denial of another service if the requested health care provider includes a written statement with supporting documentation that the service is necessary to treat a life-threatening condition or prevent serious harm to the patient. An expedited appeal is also available for denials of prescription drugs and intravenous infusions for which the enrollee is currently receiving benefits and for denied step therapy protocol exception requests.
- **Specialty Appeal:** The provider of record may request a specialty provider review the case within 10 working days from the date the appeal was requested or denied. Please see below for more information.
- **Acquired Brain Injury Appeal:** An appeal of denied services concerning an acquired brain injury.

Appeal Acknowledgment: Within five working days of receipt of the appeal, we will send the appealing party a letter acknowledging the date that we received the appeal and a list of documents that we may need for the appeal. If the appeal is oral, we will send the appealing party a one-page appeal form. The appealing party does not have to return the appeal form but we encourage its return because the form will help us resolve the appeal.

Our deadlines to resolve the appeal and send a written decision to the enrollee or someone acting on the enrollee's behalf and the provider of record are:

- **Standard / Pre-Service Appeal:** 30 calendar days of receipt of the appeal.
- **Expedited / Urgent Appeal:** One working day from the date we receive all information necessary to complete the appeal. We may provide the determination by telephone or electronic transmission but

will provide a written determination within three working days of the initial telephonic or electronic notification.

- **Retrospective / Post-Service Appeal**: 30 calendar days after receipt of appeal. However, we may extend this deadline once for a period not to exceed 15 days.
- **Acquired Brain Injury Appeal:** Not later than three business days after the date on which the individual submits the appeal. The notification of the determination must be provided through a direct telephonic contact to the individual making the request. We will provide a written determination within 30 calendar days of receipt of the appeal.
- **Specialty Appeal:** The provider of record may request a specialty appeal, which requests that a specific type of specialty review the case. The provider must request this type of appeal in writing within 10 working days from the date the appeal was requested or denied. We will complete the specialty appeal and send our written decision to the enrollee or the person acting on the enrollee's behalf and the provider within 15 working days of receipt of the request for the specialty appeal.

Determinations Not Subject to Internal Appeal: If the patient has a life-threatening condition, or in circumstances involving the denial of prescription drugs or intravenous infusions for which the patient is receiving benefits, the patient, or someone acting on the enrollee's behalf, and the provider of record can request an immediate review by an independent review organization (IRO) and is not required to follow our internal appeal procedures. See below for more information about the IRO review.

Exhaustion of Internal Appeals: We will not require exhaustion of our internal appeals process if: (a) we fail to meet our internal appeal process timelines, or (b) the claimant with an urgent care situation (life-threatening condition) files an external review before exhausting our internal appeal process or (c) if we decide to waive the appeal process requirements.

External Review by Independent Review Organization - Level 2

For Non-grandfathered plans subject to HHS-administered Federal external review process and policies subject to the ACA. Your plan or issuer may elect the HHS-administered Federal External Review: For a standard IRO review, you or someone you name to act for you may file a request for external review within four months of receiving this letter. If you would like to have another person make an external review request on your behalf, both you and your authorized representative will need to complete and sign the HHS Federal External Review Process Appointment of Representative Form. If you believe your situation is urgent, you may request an expedited external review by calling the number below immediately to begin the process. If you want to send more information to include in the review, you can send it with your request. You may use an HHS Federal External Review Request form to provide this and other additional information.

Fax: 1-888-866-6190
Mail: MAXIMUS Federal Service
3750 Monroe Avenue, Suite 705
Pittsford, NY 14534

When MAXIMUS Federal Services receives your request, they will notify us, and we'll send them all of the case information for review. If you send them any more information, they'll share it with us. We may change our decision. If not, the IRO will continue the review. You'll receive a letter with their decision. If MAXIMUS Federal Services decides to overturn our decision, we will provide coverage or payment for your health care item or service.

To request the IRO review, fill out the enclosed Maximus HHS-Administered Federal External Review Request Form. The patient or the patient's legal guardian must sign the consent to release medical information to the IRO (included as part of the IRO form).

IF the appeal cannot be faxed:
Written appeals can be mailed to: Curative, P.O. Box 1786, Austin, Texas 78767

Texas Fully Insured Complaint Procedure

You can send a complaint to us (Curative): Enrollees, individuals acting on behalf of enrollees, and healthcare providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.

Complaints to TDI: A complainant also has the right to file a complaint with TDI by contacting TDI at the following address, telephone numbers, or website:

Texas Department of Insurance
Consumer Protection (111-1A)
PO Box 12030Austin, TX 78711-2030

Toll Free Consumer Help Line
1-800-252-3439
Fax: 512-490-1007

Online: www.tdi.texas.gov

Georgia Fully Insured Complaint Procedure

You can send a complaint to us (Curative): Enrollees, individuals acting on behalf of enrollees, and healthcare providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.

Complaints to OCI: A complainant also has the right to file a complaint with Office of Commissioner of Insurance and Safety Fire (OCI) by contacting OCI at the following address, telephone numbers, or website:

Office of Commissioner of Insurance and Safety Fire
Consumer Services Division
2 Martin Luther King Jr. Dr.
West Tower, Suite 702
Atlanta, GA 30334 US

Toll Free Consumer Helpline
1-800-656-2298

Online:
https://oci.georgia.gov/insurance-resources/complaints-fraud

Florida Fully Insured Complaint Procedure

You can send a complaint to us (Curative): Enrollees, individuals acting on behalf of enrollees, and healthcare providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.

Complaints to Florida Department of Financial Services : A complainant also has the right to file a complaint with the Florida Department of Financial Services by contacting them at the following address, telephone numbers, or website:

Florida Department of Financial Services
Division of Consumer Services
200 East Gaines Street
Tallahassee, FL 32399-0322

Toll Free Consumer Helpline
FL Residents: 1-877-693-5236)
Out of State Callers: (850) 413-3089

Online:
https://www.myfloridacfo.com/division/consumers/needourhelp

Level Funded and Self Funded Complaint Procedure

You can send a complaint to us (Curative): Enrollees, individuals acting on behalf of enrollees, and healthcare providers may file a written or oral complaint about our utilization review process or procedures. Use the telephone numbers and address referenced above to file your oral or written complaint. We will respond to your complaint in writing within 30 days.

Exhaustion
The member may file a civil action under Section 502 (a) of the Employee Retirement Security Act ("ERISA") if they have exhausted their ERISA appeal rights or the claim was not approved on appeal.

Appeal Procedure

To ensure timely response to a written appeal, please include the following information and submit to:

Curative

Attn: Appeals Division
P.O. Box 1786
Austin, Texas 78767
Phone: 855-414-1089 or 512-806-0162
Fax: 888-293-4075

The following information should be included in your appeal:

1. Name of Member/Patient involved.
2. Member's ID# (subscriber #).
3. If the appealing party is someone other than the patient, include name and relationship to the
    a. patient.
4. Dates of service(s) in question.
5. Place where service(s) took place (e.g., hospital, physician's office, radiology facility, lab, home health, etc.).
6. If appeal is for emergency room services, please send a copy of the emergency room record.
7. Brief description of incident, including names, dates and times that will support resolution of the appeal.
8. Pertinent medical records.
9. The return address and phone number to whom the response should be directed.
10. All information submitted should be marked "confidential."

****Please note: An expedited appeal may be requested for emergencies or for a member already in the hospital by calling the Curative telephone number listed above.**

Curative Rx Provider Appeal Form

Written Appeal: To submit a written appeal, this form must be completed in its entirety, signed, dated, and submitted for review **within 180 days** of notification of the date of the adverse benefit determination. Please provide any supporting documents you may have, such as medical records, along with any other relevant information you may have in reference to this appeal. (i.e. Letter of medical necessity, chart notes, laboratory results, etc.). "Incomplete information will delay processing."

This form and information may be submitted via fax or mail to:

Fax #: 888-293-4075

Curative, P.O. Box 1786, Austin, Texas 78767

Patient Information:

Patient Name: _____ Date of Birth: _____

Patient ID#: _____ Date of Service: _____

Address: _____

City, State, Zip Code: _____

Prescriber information

Date: _____ Provider Name: _____

NPI: _____ Phone: _____ Fax_____

Address: _____

City, State, Zip Code: _____

Contact Name: _____

Name of the drug that you are appealing:			
Strength and dosage form		Quantity and days' supply	
Diagnosis (ICD 10 code)		Reference/ Authorization Number (s) (if applicable)	

Check Reason for Appeal:

- □ The services or treatments requested are not a covered benefit.
- □ Prior Authorization denied.

□ **Expedited / Urgent Review Requested**: By checking this box and writing my name below, I certify that applying standard appeal review timeframe may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Name of Prescriber or Prescriber's Designee:	Date:

FORM CANNOT BE PROCESSED WITHOUT REQUIRED EXPLANATION BELOW, INCLUDING THE MEDICAL RECORDS THAT SUPPORT IT

Kindly explain in detail the necessity for an appeal and provide any relevant medical documentation. (Comments, documents, records, and relevant clinical information provided by the doctor. If additional space is needed, attach additional details as necessary).

MAXIMUS Federal Services

HS-Administered Federal External Review Request Form

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MAXIMUS Federal Services needs the information on this form to review your medical claim. We may not be able to do the review without this information.

In most cases, you must complete any mandatory appeals or opportunities for reconsideration offered by your health plan or insurance issuer before we can do an external review. In urgent situations, we may be able to do a review even if you have not made all appeals and reconsiderations.

We must receive the completed form within four months of the date your insurer sent you a final decision denying your services or your claim for payment.

Please read and complete all sections of this form.

Section 1: Covered person

This section is about the person who received or will receive the benefit or treatment.

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Please complete this section if you are the covered person's parent or legal guardian

Name:	Email address:		
Street address:			
City:	County:	State:	Zip code:
Daytime phone:	Evening phone:		

Section 2: Insurance company information

Please complete this section for each insurance company involved with your claim.

Insurance company #1:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Insurance company #2:	Insurance plan or plan option *(if applicable):*
Policyholder:	Policy number:
Claim number:	Insurance company phone number:

Please attach a copy of the claim that was denied or any correspondence you have received from your insurance carrier. **Please do not send originals. Send only copies.**

Section 3: Services in dispute

Please describe the health services that were denied by your health insurance plan or issuer:

Have you already received these health services? Yes No

If so, when were the services received? *(Month, day, year)* _____

Please state the reason that you believe the health insurance company's decision was not correct:

Section 4: Claims for urgent care situations

If you believe your situation is urgent, you may ask for an expedited (fast) review.

An urgent care situation is one in which your health may be in serious jeopardy or, in your doctor's opinion you may have pain that cannot be controlled while you wait for the external review decision.

To ask for an expedited external review:

Submit an online request at https://externalappeal.com OR Fax this form to 1-888-866-6190 OR Mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

In urgent care situations, MAXIMUS Federal Services will accept a request for external review from a medical professional who knows about the claimant's condition. The medical professional will not be required to submit proof of authorization.

If you have questions about your external review, call: **1-888-866-6205**.

Is this external review for urgent care? Yes No

Section 5: Claims involving a rescission of coverage

A **rescission** is an action by a health insurance issuer to retroactively cancel (back to an earlier date) or discontinue a policyholder's coverage.

Is this request for external review of a rescission of health insurance coverage? Yes No

Section 6: Additional information you may give

MAXIMUS Federal Services will use the information on this form to get the relevant information and documents from your insurer. You may add supporting information and documents you think the insurer may not be able to provide.

For example, you may choose to give us:

- Documents to support the claim, such as physicians' letters, reports, bills, medical records, and Explanation of Benefits (EOB) forms
- Letters you sent to your insurance plan or issuer about the claim
- Letters the plan or issuer sent to you about the claim

You do not have to give us this additional information. However, if you do not give us any additional information, MAXIMUS Federal Services may decide your case based only on the information your insurance issuer or plan gives us.

You can give MAXIMUS additional information for your external review by sending it with this form:

Fax to 1-888-866-6190 **OR** mail this form to:

HHS Federal External Review Request, MAXIMUS Federal Services, 3750 Monroe Avenue, Suite 705, Pittsford, NY 14534.

If you have questions about your external review, call **1-888-866-6205**.

Sign the consent form.

Signature and Release of Medical Records - Please sign and date the consent.

To appeal your health carrier's denial, you must sign and date this external review request form and consent to the release of medical records.

I hereby request an external appeal. I attest that the information provided in this application is true and accurate to the best of my knowledge. I authorize my insurance company and my health care providers to release all relevant medical or treatment records to MAXIMUS Federal Services. I understand that MAXIMUS Federal Services will use this information to make a determination on my external appeal and that the information will be kept confidential and not be released to anyone else.
This release is valid for one year.

Signature: _____ Date: _____

Printed name: _____

I am the: ☐ Covered person ☐ Parent or legal guardian ☐ Authorized Representative

NOTE: The covered person must sign this consent form, unless they have a legal guardian, personal representative, are incapacitated, or have otherwise delegated authority to complete this form. If the covered person cannot sign this form, the authorized representative must give written proof of his or her authority to sign. You may obtain the Authorized Representative form at https://externalappeal.com/ferpportal/#/forms.

Privacy Act Statement: The following website provides a notice of your rights under the Privacy Act and includes information about how the information on this form will be used and about our legal authority to collect this information: http://cciio.cms.gov/resources/other/index.html.