STATE HEALTH BENEFITS PROGRAMS APPEAL FORM

Persons enrolled in COVA Care, COVA HealthAware, COVA HDHP (High Deductible Health Plan), Advantage 65, Advantage 65 with Dental/Vision, Option I or Option II may use this form to appeal to the Director of DHRM on matters of eligibility, regardless of the State plan in which the appellant is enrolled. ***To be considered a valid appeal, the Director must receive it within four (4) months of the final adverse decision of the Plan Administrator.***

NOTE: Matters in which the sole issue is disagreement with policies, rules, regulations, contract or law cannot be appealed to DHRM. The decision of the Plan Administrator is final in these cases.

Your Name ` **Patient Name**
Name of Enrolled Employee **Member ID #**
Address
City **State** **Zip**
Home Phone **Business Phone**
Service or Supply requested **Date of Service**
Name of Physician, Hospital, or Other Health Care Provider

CHECK ONE OR MORE OF THE FOLLOWING REASONS FOR THE APPEAL:

- ☐ Believe the claim was for a covered service and should not be denied for payment.
- ☐ Believe a service met the Health Plan's requirements for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness of a covered service, though denied, reduced or terminated.
- ☐ Believe a service was medically necessary, though denied as experimental/investigational.
- ☐ Eligibility or "Other" Issue.

PLEASE DESCRIBE THE REASON(S) YOU ARE FILING THIS APPEAL:

WHAT SPECIFIC REMEDY DO YOU SEEK IN FILING THIS APPEAL?

DOES THIS QUALIFY FOR AN EXPEDITED APPEAL (please refer to your Member Handbook) AND ARE YOU REQUESTING AN EXPEDITED APPEAL? ☐ Yes or ☐ No

PLEASE ATTACH DOCUMENTS RELEVANT TO YOUR APPEAL. For example: Explanation of claims processed, other correspondence from plan, letter from your physician, bill from your health care provider, the plan administrator's final denial, or any other information you want considered. Are documents attached? ☐ Yes or ☐ No

APPEALS TO THE DIRECTOR OF THE DEPARTMENT OF HUMAN RESOURCE MANAGEMENT should be addressed as follows:

Director, Department of Human Resource Management
101 North 14th Street – 13th Floor
Richmond, Virginia 23219-3657
Please mark the envelope **Confidential – Appeal Enclosed**

MEMBER'S SIGNATURE _____ **DATE**

This form must be signed by the Member. If this form is being signed by anyone other than the Member, please complete the next section. To be completed only if the member wishes to appoint someone to represent them during the appeals process.

NAME OF AUTHORIZED REPRESENTATIVE:

NOTE: For appeals related to **medical or mental health and substance abuse claims**, you must submit a completed **HIPAA Authorization Form** to DHRM before the appeal can be processed. The form is available on the DHRM Website at www.dhrm.virginia.gov under Appeals or from your Benefits Administrator.

Health Benefits Plan for State and Local Employees
AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

EMPLOYEE/RETIREE
Name: ID Number:
MEMBER
Name: ID Number:
Date of Birth:

DESCRIPTION OF INFORMATION TO BE USED OR DISCLOSED:

WHO IS AUTHORIZED TO USE OR DISCLOSE THE INFORMATION?

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION?

REASON THE INFORMATION WILL BE USED OR DISCLOSED [if the member initiates the authorization, the statement "at the request of the individual" is sufficient]:

EXPIRATION DATE OR EVENT:

Notice to Member

You may revoke this authorization at any time. To revoke this authorization, send a written statement to the Office of Health Benefits, 12th Floor, Privacy Official, 101 N. Fourteenth St., Richmond VA 23219. The statement must identify this authorization by referring to the date it was signed (below). The statement must include the date on which this authorization is no longer in force.

If you revoke this authorization, we may still use and disclose the information for the purposes listed above, if we have already taken action in reliance on this authorization. Also, if this authorization is to permit disclosure of information to an insurance company, in order for you to obtain insurance coverage, the insurance company may still have the legal right to use the information to contest a claim or to contest your coverage.

You may refuse to sign this authorization. You do not need to sign this authorization to receive health care services.

You do not have to sign this authorization to receive payment, to enroll in Health Benefits Plan for State and Local Employees' health benefit plan, or to be eligible for benefits, except:

If this authorization is sought is for the purpose of determining your eligibility for benefits or enrollment, then you must authorize the Plan to obtain the necessary information or the benefits or enrollment may be denied.

Under Federal law, you do not have to authorize us to receive the private notes from counseling sessions, that are kept by a mental health professional, as a condition of payment, enrollment in a employee health benefit plan, or eligibility for benefits.

A person or organization that receives your information because of this authorization may have the legal right to disclose this information to other people or organizations without your knowledge or consent.

Signature: _____ **Date:**

If this authorization is signed by someone who is not the member listed at the top of this form, provide a description of the signer's authority to act for the member.
