STATE HEALTH BENEFITS PROGRAMS APPEAL FORM
Department of Human Resource Management (DHRM)

Persons enrolled in COVA Care, COVA HealthAware, COVA HDHP (High Deductible Health Plan), Advantage 65, Option II, or LODA may use this form to appeal adverse claim determinations to DHRM. All members eligible for the state health benefits program may use this form to appeal administrative determinations, such as eligibility or enrollment issues to DHRM.

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** _____

Employee/Retiree Name_____ **ID #** _____

Address _____

City _____ **State** _____ **Zip** _____

Home Phone (___)_____**Business Phone** (_)_____ _____

Please include an email address, if available _____

Service Requested_____ **Date(s) of Service** _____

Name of Physician, Hospital, or Other Health Care Provider _____

CHECK ONE OR MORE OF THE FOLLOWING:

☐ elieve the claim was for a covered service and should not be denied for payment.
☐ elieve 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.
☐ elieve a service was medically necessary, though denied as experimental/investigational.
☐ dministrative - Eligibility or non-claim related issue.

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

WHAT SPECIFIC REMEDY DO YOU SEEK IN FILING THIS APPEAL?

ARE YOU REQUESTING AN EXPEDITED APPEAL (consult your Member Handbook for qualifications)?

☐ Yes or ☐ No

PLEASE INCLUDE DOCUMENTS RELEVANT TO YOUR APPEAL. (Explanation of benefits (EOB), final determination letters and other correspondence from plan administrator, letters and itemized bill(s) from your health care provider, and any other information you want considered.) Are documents included? ☐ Yes or ☐ No

APPEALS should be addressed as follows:

Director, Department of Human Resource Management
600 East Main Street, 17th 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 other than the Member, please include a Power of Attorney (POA) that allows the signee to act on the behalf of the member/patient in medical (health care) issues.

NAME OF AUTHORIZED REPRESENTATIVE: _____

AUTHORIZED REPRESEMTATIVE EMAIL:_____

To be completed only if the member wishes to appoint someone to represent them during the appeals process. Please include a signed Designation of Representation (DOR) form or letter.
NOTE: For appeals related to **claim determinations**, you must submit a completed **HIPAA Authorization Form** to DHRM before the appeal can be processed.

Health Benefits Program for State and Local Employees

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION OF 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 [i.e., DHRM, External Review Organization, Health Plan, Provider, if applicable]?

_____

WHO IS AUTHORIZED TO RECEIVE THE INFORMATION [i.e., DHRM, External Review Organization, Health Plan, Provider, if applicable]?

_____

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, 17th Floor, Privacy Official, 600 East Main 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 Program 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, which are kept by a mental health professional, as a condition of payment, enrollment in an 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.

_____

_____