

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, or Option II may use this form to appeal adverse claim determinations to DHRM. Before filing a health care appeal to the Director of DHRM, you must exhaust all health care appeals through your plan administrator. Please review the appeals information in your health plan member handbook. For appeals related to **claim determinations**, a completed **HIPAA Authorization Form** must be included with your request before the appeal can be processed.

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 valid, the Director must receive the appeal within four (4) months of the final adverse decision.

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.

To file an appeal by **traditional mail**, send your request to the following address:

Director, Virginia Department of Human Resource Management
101 N. 14th Street – 12th Floor
Richmond, VA 23219

Please mark the envelope: Confidential – Appeal Enclosed

To file an appeal by email, send your request to **appeals@dhrm.virginia.gov**

To file an appeal by facsimile, fax your request to **804-786-0356**

STATE HEALTH BENEFITS PROGRAMS APPEAL FORM
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Your Name _____ Patient Name _____
Employee/Retiree Name _____ ID # _____
Address _____
City _____ State _____ Zip _____
Home Phone (____) _____ Business Phone (____) _____
Service Requested _____ Date(s) of Service _____
Name of Physician, Hospital, or Other Health Care Provider _____

CHECK ONE OR MORE OF THE FOLLOWING:

- Believe the claim was for a covered service and should not be denied for payment.
- Believe a service meets the Health Plan's requirements for medical necessity, appropriateness, healthcare setting, and/or 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.
- Administrative - 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

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: _____

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.

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?

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 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.

