Health and Prescription Plan Appeal Form and Checklist for Filing a Level III Appeal of prior denial to The Statewide Benefits Office (SBO)

Any non-Medicare member of the State of Delaware's Group Health Insurance Program may request that the Statewide Benefits Office (SBO) conduct a Level III appeal of the processing of health care or prescription services provided by Aetna, Highmark Delaware or Express Scripts for him/her-self, covered spouse or covered child/ren.

*Members of the State of Delaware Group Health Insurance Program should complete and submit this appeal form **only if**:*

1. You have received both Level I and Level II appeal denials from Highmark Delaware, Aetna or Express Scripts in writing and it is within 20 days of the postmark date of the notice of the Level II denial, or
2. You received a Level I expedited appeal denial from Highmark Delaware, Aetna or Express Scripts in writing and it is within 20 days of the postmark date of the notice of the Level I expedited appeal, or
3. You received a Level III appeal decision from an Independent External Review Organization conducted at your request through Highmark Delaware, Aetna or Express Scripts.

Please visit www.ben.omb.delaware.gov/medical or www.ben.omb.delaware.gov/script and review the "Appeal Process" for your specific health or prescription carrier.

To file a Level III appeal in writing to SBO, complete the following checklist items:

□ Indicate which of the above situations apply to your Level III appeal request (1, 2 or 3) _____

□ Include copies of your **prior appeal level requests** and the **denial letters from your carrier**.

□ Fill out the following **information**:

Subscriber (Primary SOD benefit holder)
First Name: _____ Last Name: _____

Member (Person whose coverage is being appealed)
First Name: _____ Last Name:_____

Member Home Mailing Address/Street: _____

City: _____ State: _____ Zip Code: _____

E-mail Address (if applicable): _____

Daytime Telephone Number (between 8:00 A.M. to 4:30 P.M.):

(_____) _____ - _____

Subscriber's Work Agency/Department or School District Name (If a retiree, please put "pensioner"):

_____

Subscriber's Employee ID or Pensioner ID Number _____

Health or Prescription Plan (Fill in the circle next to your plan related to this appeal):

Highmark Delaware O First State Basic O CDH Gold O IPA/HMO O Comp PPO

Aetna O CDH Gold O HMO

Prescription Plan O Express Scripts (non-Medicare Prescription Plan)

Member ID Number (see Member ID Card): _____ *OR*

Member Social Security Number: _____

Concern/Appeal is for services provided to (Fill in the appropriate circle):
O Self O Spouse O Child/ren

If Spouse or Child, provide Spouse or Child's Name and Date of Birth:

First Name: _____ Last Name: _____

Date of Birth (MM/DD/YYYY): _____/_____/_____

□ Complete and include the **State of Delaware Authorization for Release of Protected Health Information Form** (located at www.ben.omb.delaware.gov/medical or www.ben.omb.delaware.gov/script under your health or prescription carrier link). If appeal is for the member's spouse or child 18 years of age or older, then spouse or child must complete and sign the State of Delaware Authorization for Release Protected Health Information form.

□ As a separate document, provide the **reason for your appeal**. This must include a detailed explanation as to why the denial should be overturned. The explanation should include

specifics regarding the benefit your plan provides, what service or coverage was not provided or paid on your behalf according to your plan coverage, and the services for which you are requesting coverage. For example, "My plan states that the Emergency Room (ER) fee will be waived if the patient is admitted to the hospital. On the date in question, I went to the ER, and was admitted to the hospital later that same day. I was charged a copay for the ER visit. I believe it should be waived."

□ Include **medical documentation** relevant to your appeal**:**

- ✓ Physician (office notes), lab, hospital and emergency room records
- ✓ Dates of service, claim numbers and claim amounts
- ✓ Explanation of Benefits (EOBs)
- ✓ Medical necessity approval from physician (this is required for the health plan to cover the cost of services)

Submit all of the items in this checklist/form as one complete packet of information to SBO by fax at 302-739-8339 or by U.S. Mail at:

Appeals Administrator
RE: APPEAL
Statewide Benefits Office
97 Commerce Way, Suite 201
Dover, DE 19904

Please note: The Appeals Administrator from SBO (or his/her designee) will conduct an internal review of the appeal and provide a written notice of the decision to the employee and his/her health carrier within 30 days of receiving this packet of information.

Have questions or concerns regarding this form?
Contact SBO at (302) 739-8331 or (800) 489-8933.