Capital Health PLAN℠

An Independent Licensee of the Blue Cross and Blue Shield Association

Complaint, Grievance and Appeal Process

Capital Health Plan has established a process for reviewing member complaints, grievances, and appeals. The purpose of this process is to facilitate review of, among other things, any member's dissatisfaction with Capital Health Plan, Capital Health Plan administrative practices, coverage, benefit or payment decisions, or with the administrative practices and/or the quality of care provided by any independent contracting provider. The Complaint, Grievance, and Appeal Process also permits the member, or his or her physician, to request expedited review of certain types of appeals. The process described below must be followed if the member has a complaint, grievance, or appeal.

Capital Health Plan encourages the member to attempt informal resolution of any dissatisfaction by calling Capital Health Plan Member Services at 850-383-3311 (toll-free 1-877-247-6512); TTY 850-383-3534 (toll-free 1-877-870-8943). If Capital Health Plan is unable to resolve the matter on an informal basis, the member may submit his or her formal request for review in writing.

Definitions:

Appeal - a written request for Capital Health Plan to review and overturn a previous decision to deny coverage or payment for health care services, supplies or drugs. A member, member's representative, provider acting on behalf of a member, or state agency may submit an appeal. To submit or pursue an appeal on behalf of a member, a health care provider must have been directly involved in the treatment or diagnosis of the member. Expedited appeals may be submitted verbally.

Complaint - an oral (i.e., non-written) expression of dissatisfaction by an enrollee to CHP or provider

Expedited Appeal – a request for CHP to reconsider and change a decision, where the use of the standard appeal time frame would seriously jeopardize:

- the life or health of the member, or
- the member's ability to regain maximum function, or
- the member's pain cannot be adequately managed without the care or treatment that is the subject of the request.

Federally Administered External Review Program - a program offered by the federal government that provides, upon request of the member, treating physician or authorized representative, independent review of the appeal that was not resolved by the health plan to the satisfaction of the member. The member bears no costs for this independent review.

Grievance – a written complaint, dispute or expression of dissatisfaction, which does not involve a previous CHP decision. The member, provider acting on the member's behalf, designated representative or state agency, may submit a grievance.

Post-Service Appeal - any request for approval of a service or payment for a service that has already occurred. Note: Post-service requests are not eligible for expedited processing.

Pre-Service Appeal - any request for approval of a service or payment for a service that has not yet occurred

Time frames for Grievances and Appeals –please note time frames begin when Capital Health Plan has received all necessary information.

Type of Request	**Commercial Members**	**Federal Members**	**State of Florida Members**
Expedited Appeal (Pre-Service only)	72 hours	72 hours	72 hours
Pre-Service Appeal	30 days	30 days	15 days
Post-Service Appeal	60 days	30 days	30 days
Grievance	30 days	30 days	30 days

Contact Information

Capital Health Plan Member Services Department Representatives are available to take your calls at 850-383-3311 or 1-877-247-6512 (TTY 850-383-3534 or 1-877-870-8943) 8:00 a.m. – 5:00 p.m., Monday – Friday. State of Florida members call 1-877-392-1532, 7:00 a.m. – 7:00 p.m.

Local Address: 1264 Metropolitan Boulevard, Tallahassee, FL 32312

Office hours: Monday – Friday, 8 a.m. to 5 p.m.

Mailing Address: Capital Health Plan, P.O. Box 15349, Tallahassee, FL 32317-5349

Fax: 850-383-3413 (secure fax)

Website: http://www.capitalhealth.com