SmartHealth®

Appeal process for EPO members

What is an appeal?
An appeal is a written request by you or your authorized representative (For example, your provider) to dispute the adverse decision related to your coverage. Before submitting an appeal, contact the SmartHealth Customer Service team at 888-492-6811 to review any adverse coverage determinations. This team may be able to resolve your issue quickly outside of the formal appeal process. If not, they will advise you of your appeal rights.

To avoid having to submit an appeal, ensure you have a prior authorization or benefit elevation before services are rendered. Find services that require an authorization and benefit elevation requirements on mysmarthealth.org.

Different types of appeals:

- **Appeal of pre-service claim**
  - A prior authorization (PA) request for a service on the PA list is denied *before* services are rendered.
  - A referral request to receive services from an out-of-network provider is denied *before* services are rendered.
- **Appeal of post-service claim**
  - Service(s) have been rendered and you receive an adverse benefit determination related to your coverage.

How to submit an appeal:

Pre-Service Appeals:
You will need to send a detailed letter including an explanation of the reason why the service should have been approved and any additional supporting information, materials, or documentation.

Submit all the above to:

Ascension Care Management Insurance Holdings
Attention: Appeals Department
Fax: 586-693-4768
Mail: 1345 Philomena St. Suite #305
Austin, TX 78723

Post-Service Appeals:
1. Complete and submit an appeal form along with any supporting documentation to the address below.

SmartHealth Appeals
Fax: (586) 238-4363
Mail: PO Box 32112
Detroit, MI 48232

Ascension

2. Supporting documentation may include the following: Copy of the claim, explanation of payment (EOP) and/or explanation of benefit (EOB), adverse decision letter, a letter from your provider and applicable medical records. **Accurate and complete preparation of your appeal is important for a timely and thorough review.**

How long do I have to submit my appeal?
In most cases you have **180** days to appeal the first adverse benefit determination.

Retrospective authorization: If you received services that require prior authorization and no authorization was obtained, you have **30** days from the date of service to appeal in the following extenuating circumstances:

- The provider and/or facility was unable to identify from which health plan to request an authorization. You were not able to tell the provider about your insurance coverage, or the provider verified different insurance coverage prior to rendering services.
- You required immediate medical services and the provider was unable to anticipate the need for a prior authorization immediately before or while performing a service.
- You were discharged from a facility and insufficient time existed for institutional or home health care services to receive approval prior to the delivery of the service.

In each case, the provider was unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement. All retrospective review requests must include the reason/explanation for not submitting an authorization request prior to rendering services.

After 30 days from the date of the service, the initial decision is considered final and may no longer be appealed.

Referral: If you received services from an out-of-network provider and a referral was not obtained, the services are not covered. Please refer to mysmarthealth.org for a list of SmartHealth providers. **Note: there are NO retrospective referrals available under the plan after out-of-network services are received; if you do not receive an approved referral prior to obtaining services from an out-of-network provider, the services will not be covered and you will be responsible for the full cost of the services.**

How long will it take my appeal to be reviewed?

- **Pre service:** 30 days for a standard request and 72 hours for urgent requests.
- **Post service:** 60 days, however most are reviewed within 30 days.

You will receive an appeal decision in writing. If you disagree with the decision, you may file a second appeal within **60** days after receiving the decision. To file the second appeal you can send it to the address below.

SmartHealth Advisory Committee
Fax: (586) 238-4363
Mail: SmartHealth Advisory Committee
PO Box 321125
Detroit, MI 48232

Who will review my appeal?
A qualified person/committee who was not involved in the initial decision will review your appeal.

With questions, call Customer Service at 888-492-6811.
This is a brief overview of claim denials and appeals, which is subject to change. To resolve any conflict between this overview and the Summary Plan Description, you should consult the plan document, which will prevail over both this overview and the Summary Plan Description. For further details about plan benefits, please contact customer service at the number shown on the back of your ID card, or view the official summary plan description at mysmarthealth.org.