Network Health: Member Appeals

Appeal: The member level process of disputing an adverse benefit determination through Network Health. This includes any denial, reduction or termination of a benefit and any rescission of coverage.

An appeal may be an appropriate next step for a maintained adverse determination of an authorization request following the completion of the Peer to Peer and/or Reopening process, or if the time frame for completing these options has passed. Appeal rules for Commercial and Medicare Members are different. Commercial grievance rules may vary by plan type.

Please contact the Member Experience Department with any Appeal questions:

Medicare Plans:

- Phone: 800-378-5234 or 920-720-1345
- SNP Phone: 855-653-4363 or 920-720-1490
- Provider Phone: 855-580-9935 or 920-720-1460

Commercial Plans (HMO/POS):

- Phone: 800-826-0940 or 920-720-1300

State of WI (ETF) Plans:

- Phone: 844-625-2208 or 920-720-1811

HIX (HPN_NE/HPN_SE) and IFP Plans:

- Phone: 855-275-1400 or 920-720-1400

Assure Level Funded/LLC/Self-Insured Plans (SPD):

- Phone: 844-300-5537 or 920-720-1370

Horizon Home Care & Hospice:

- Phone: 877-780-6717 or 920-720-1362

Commercial Plans: Grievance Process

Request for a grievance must be received in writing. Please always include the name and contact information for the individual filing the grievance as well as a short description of what is being appealed. Member Experience is available to assist with triaging urgent appeal requests.

Grievance requests can be **mailed** to:

Network Health
Attn: Appeals and Grievance Specialist
P.O. Box 120
Menasha, WI 54952

You can also **fax** the information to Network Health at 920-720-1832.

Time Frames: The time frame for submission of a grievance begins on the date of the adverse determination by Network Health. Submission time frames vary based on the Commercial Insurance Plan type (example: State of Wisconsin (ETF) members have 90 days from the date of adverse determination. Self-Funded/Level funded (SF/SPD) members have 180 days from the date of adverse determination. Health Insurance Exchange (HIX) members have three (3) years from the date of adverse determination). **Please contact Member Experience for details for submission timeliness for your individual plan type.**

Who Can Submit: The Member or a Participating provider may submit a grievance of an adverse determination. Non-Participating providers can submit a grievance ONLY after a signed (appointment of authorized representative) AOR form has been completed by the member. If there is no signed AOR form, a Non-Participating provider cannot submit a grievance on behalf of a member.

Please note: An AOR form must designate a specific person to represent a member during the grievance and not a company.

Self-Funded and Level Funded Plan participants require a signed AOR form for any grievance not submitted by the participant. This includes Participating Providers.

Link to AOR Form: https://networkhealth.com/__assets/pdf/employer-plans/Authorized%20Representative%20Form.pdf

Once the Grievance has been received by Network Health, an Appeals and Grievance Specialist will reach out to you with any additional notifications, additional information, or additional forms needed to complete the grievance. A written notification of the grievance decision will be sent in writing.

Medicare Plans: Appeal Process

A Medicare appeal can be submitted by call, fax, letter or in person. Please always include the name and contact information for the individual filing the appeal as well as a short description of what is being appealed.

Requests for appeal can be made verbally by **calling**:

- Phone: 800-378-5234 or 920-720-1345
- SNP Phone: 855-653-4363 or 920-720-1490
- Provider Phone: 855-580-9935 or 920-720-1460

Member experience will complete a Complaint Assessment form which is then triaged through an Appeals and Grievance Specialist.

Requests for appeal can be **mailed** to:

Network Health
Attn: Appeals and Grievance Specialist
P.O. Box 120
Menasha, WI 54952

You can also **fax** the information to Network Health at 920-720-1832.

Time Frames: The time frame for submission of an appeal begins on the date of the adverse determination by Network Health. A Medicare appeal must be submitted within 60 days of the determination of denial.

Who Can Submit: Appeals can be submitted by a member, spouse, family friend, attending provider, power of attorney, agent, or any individual appointed by the member to speak on their behalf. If an appeal is submitted by the member or the attending Medical Doctor (this does not include advanced practice practitioners) no additional forms will be needed. Additional forms may be required for any other individual submitting an appeal. Once the appeal is received by Network Health, an Appeals and

Grievance Specialist will outreach to you with the additional forms that will be needed to complete your appeal.

Medicare Advantage non-participating providers have 60 calendar days from the date of the original remittance advice to submit a provider appeal. Appeal requests must include signed Waiver of Liability (WOL). A signed waver of liability is needed on file for a Non-Participating provider to file an appeal. An Appeal and Grievance Specialist can assist in providing any forms required after the appeal request is received by Network Health.

Once the Appeal has been received by Network Health, an Appeals and Grievance Specialist will reach out to you with any additional notifications, requests additional information, or additional forms needed to complete the appeal. A notification of the appeal decision will be sent in writing.