

## Important Information about Your Appeal Rights

When an adverse benefit determination (e.g., a request for preauthorization that was denied in whole or in part) has been made, you may appeal the adverse benefit determination. Below are some commonly asked questions and answers related to your appeal rights.

**What if I need help understanding a denial letter I received?** Contact us at MaxorPlus at 1-800-687-0707 if you need assistance understanding this notice or this decision.

**What if I don't agree with the decision?** You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

**How do I file an appeal?** Complete the Appeal Filing Form (next page), make a copy, and send this document to MaxorPlus- Attn: Clinical Department, 320 S. Polk St., Amarillo, Texas 79101. You may also fax this information to MaxorPlus-Attn: Clinical Department to 866-222-3274 or call MaxorPlus at 1-800-687-0707. MaxorPlus will refer this information to the required party according to your Plan's specifications. See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

**What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician; you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also by filing an appeal for external review at the same time. Contact your benefits administrator or MaxorPlus for the External Appeal Filing Form.

**Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an appeal. There is a place to designate an authorized representative on the Appeal Filing Form (next page). You must sign the authorization on the appropriate signature line.

**Can I provide additional information about my claim?** Yes, you may supply additional information. You can supply the information with the Appeal Filing Form to MaxorPlus- Attn: Clinical Department, 320 S. Polk St., Amarillo, Texas 79101. You may also fax this information to MaxorPlus-Attn: Clinical Department to 866-222-3274 or call MaxorPlus at 1-800-687-0707. MaxorPlus will forward this information to the required party according to your Plan's specifications.

**Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge) including the prior authorization criteria used to make the decision. If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting MaxorPlus at 1-800-687-0707.

**What happens next?** If you appeal, once the appeal is reviewed by the required party, you will be sent a written determination. If the Plan continues to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external

review of your claim by an independent third party, who will review the denial and issue a final decision.

**Other resources to help you:** For questions about your rights, this notice, or for assistance, you can contact: the Employee Benefits Security Administration at 1-866-444-EBSA (3272).



## Appeal Filing Form

**Person Filing Request For Appeal:**

**Circle one:**

Enrollee/Patient    Authorized Representative    Health Care Provider    Parent of minor child under 18

**Contact information of person filing request for appeal (if different from patient)**

**Name of Person Filing Request:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Daytime phone:** \_\_\_\_\_ **Email:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**If person filing request for appeal is other than patient, patient must indicate authorization by signing here:**

\_\_\_\_\_  
**Patient Signature**

**I am requesting an urgent/expedited review\* because the member’s health, life or ability to regain maximum function may be seriously jeopardized** or, in the opinion of member’s physician, member may experience pain that cannot be adequately controlled while **waiting for a standard coverage determination?**                      \_\_\_\_\_ Yes                      \_\_\_\_\_ No

\*If you require an urgent External review, you will also need to submit an External Appeal Filing Form along with this form. Contact your benefits administrator or MaxorPlus for this form.

**BRIEFLY DESCRIBE WHY YOU DISAGREE WITH THIS DECISION** (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Send this form AND your denial notice to:** MaxorPlus- Attn: Clinical Department, 320 S. Polk St., Amarillo, Texas 79101 or fax this information to MaxorPlus-Attn: Clinical Department to 866-222-3274 or you may call 1-800-687-0707.

**Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.**