Part 6 – How to resolve a problem with Anthem

We care about the quality of care you get from us and your doctors. If you have a concern, call us at Member Services at 1-866-408-6131 (TTY 711), Monday through Friday, 8 a.m. to 8 p.m. Eastern time.

Here are some things we can help you with:

- Finding a doctor
- Finding care and treatment
- Issues about how we run the health plan
- Any aspect of your care

You will not be treated differently because you call us with a problem or complaint.

If you have a question

If you're not happy with the care you get from one of the doctors in your plan, please let us know. There are two ways you, or someone you choose to act for you, can let us know your problem:

- **Call us at** 1-866-408-6131 (TTY 711).
- **Send us a letter at:**
  Anthem Blue Cross and Blue Shield
  P.O. Box 62429
  Virginia Beach, VA 23466

Our Member Services staff will try to take care of your problem right away. They may have to send the information to the right staff person for a final answer. You may choose not to be named when you tell us, or send us information about, your problem.

Grievances

A grievance can be filed with us over the phone or in writing. You need to file your grievance within 60 calendar days from the date the problem took place.

If you have questions or concerns about your care, try to talk to your doctor first. Then if you still have questions or concerns, call us.

If you need help filing your grievance, one of our associates can help you. If you do not speak English, we can get an interpreter for you.

What if my problem has to do with a denial of my benefits?

You need to file an appeal instead of a grievance. Learn how to *Make an appeal*. The information is located in this section.

You have three ways to file a grievance with us

1. **Call Member Services** at 1-866-408-6131 (TTY 711).
2. **Complete a grievance form** found on www.anthem.com/inmedicaid.
3. **Write us a letter** to tell us about the problem.

These are the things you need to tell us as clearly as you can:

- Who is involved in the grievance
- What happened
- When did it happen
- Where did it happen
- Why you're not happy

Send your completed form or letter, along with any documents, to:

Grievance Coordinator
Anthem Blue Cross and Blue Shield, P.O. Box 62429, Virginia Beach, VA 23466

If we can't make a decision about your grievance within 30 calendar days, we can ask the state agency to give us extra time (up to 14 calendar days). If we do this, we'll send a letter to tell you why we need more time.

Expedited (rush) grievance

Members must request an expedited grievance by fax only. Please fax to 1-855-516-1083.

If you think waiting 30 calendar days may harm your health, we may be able to give you an answer within 48 hours. This is called an expedited (faster) grievance. In your request, tell us why you think waiting 30 calendar days would harm your health. We'll make a decision and try to call you within 48 hours from the time we get your grievance. We also will send you a letter within five business days after making our decision.

You also need to show facts proving your claim. This needs to be done within a certain time period. A medical director reviews requests for faster appeals. If the medical director thinks waiting 30 calendar days won't harm your health, we'll send you a letter within two business days to let you know we'll complete your grievance as quickly as we can but within 30 calendar days. We'll also try to call you to tell you our decision.

Appeals

If you want to file an appeal about how we solved your problem, an appeal can be requested within 60 calendar days from the day of our decision on the grievance resolution letter.

Send your appeal to:

Appeals Department
Anthem Blue Cross and Blue Shield, P.O. Box 62429, Virginia Beach, VA 23466

We'll send you an acknowledgement letter within three business days after we get your appeal. The letter will tell you we got your appeal request.

You can also ask for an appeal by calling Member Services at 1-866-408-6131 (TTY 711). You must ask for an appeal in writing after you ask for one over the phone, unless you ask for a rush appeal.

We'll make a decision about your appeal within 30 calendar days after we get it. If we cannot decide within 30 calendar days, we can ask the state agency to give us more time (up to 14 calendar days). If we do this, we'll send you a letter to tell you why we need more time.

Once your appeal is resolved, we'll send you a letter to tell you about the decision explaining:

- How to file an external independent review request.
- Ways to get a faster review.
- Your right to keep your benefits during the review.
- That you may have to pay for care you get while you wait for the decision.

Expedited (rush) appeal

Members must request an expedited appeal by fax only. Please fax to 1-855-516-1083.

You may ask us to rush your appeal if your health needs it. We'll let you know we got your appeal within 24 hours from the time we received it. We send you a letter with our decision within 48 hours. If we say no to your request for a rush appeal, we'll call and send you a letter with the reason for the delay within two calendar days.

You may keep your benefits while you're waiting for your appeal if you asked for the appeal within the right time frame. You may have to pay for the care you get while you wait for an answer about the appeal if the final decision is not what you wanted.

External independent review

We have a special process called an external independent review (EIR). This process provides a neutral review of benefit decisions made by Anthem.

The EIR is used to resolve grievance appeals if we said no to paying for a service:

- You or your doctor asked for.
- That has to do with your medical needs.
- You asked for that has not been proven to work.

A written request must be filed for this process. This must be filed within 120 calendar days for Hoosier Care Connect or 33 calendar days for Healthy Indiana Plan and Hoosier Healthwise from the date we told you that your appeal had been denied. Within three business days after we get your request, we'll send you a letter to say we got it.

EIRs are resolved within 15 business days from the date of request. We'll send you a letter with the answer within 72 hours from when we decided. The letter will explain:

- Your right to ask for a Medicaid hearing.
- How to ask for a hearing.
- Your right to keep your benefits until the hearing is over.
- That you may have to pay the costs for services that you're waiting for if the decision is not what you asked for at the start.

Expedited (rush) external independent review

You may ask us to rush your external independent review (EIR) if your health needs it. Members must request an expedited external independent review by fax only. Please fax to 1-855-516-1083.

We'll take care of your request as fast as we can, but no more than 72 hours from the time we get your appeal. We'll send you a letter within 24 hours after we make a decision.

Medicaid hearing and appeal process

If you have a problem with what we decide after completing our appeal process, you can ask for a Medicaid hearing and appeal review. You may ask for this review if we:

- Said no to paying for a service you wanted.
- Said OK to a service, but then we put limits on it.
- Ended payment for a service that we said OK to before.
- Did not give you access to a service fast enough.
- Did not confirm you were medically frail.

To ask for a review, you must send a letter to the state Medicaid agency within 120 calendar days of getting our decision about your appeal. Send your request to:

FSSA Hearings and Appeals
RM E034 — IGC-S, MS04, 402 W. Washington St., Indianapolis, IN 46204

Steps to take if you're unhappy:

A judge will hear your case and send you a letter with the decision within 90 business days of the date that you first asked for a hearing.

If you have a problem with the judge's decision, you can ask for an agency review. You must file for this review within 10 business days after you get your notice of the judge's decision.

You'll get a written notice of action from the agency review. If the hearing decision was reversed or changed, a letter will give the reasons.

If you're not happy with what the agency decides, you may file for a judicial review.