Anthem Medicaid

Appeal process for Anthem Medicaid members

You can appeal

If you disagree with our decision not to approve the service your doctor asked for, you have the right to file an appeal. You can file an appeal about any Medicaid service, including EPSDT services. We'll answer your concerns quickly and privately.

You must file your appeal within 60 calendar days of the date on the letter when we told you we did not approve the requested service. You can choose anyone to represent you, including your doctor or attorney during the appeal process. If you ask someone to represent you, give them a signed consent to send with the appeal request.

We will not discriminate or punish you or your representative for filing an appeal.

If the appeal review doesn't change our decision, we'll send you and your doctor a letter with the reasons why. You or your representative can ask for and get at no charge:

- Copies of all documents, records and other new or additional facts about the appeal.
- Any rule or guideline used in the decision(s).
- The reason for the scientific or clinical judgment related to your condition if we decided the care you asked for wasn't medically necessary (needed for your care) or that it was experimental in nature.
- The names of the doctors or experts in the area under review who gave us advice about your appeal, whether or not we used their advice to make the decision.

How to file an expedited (fast) appeal

If you haven't had services or if you're getting them now, we may expedite your appeal if you, your representative or your doctor think your condition:

- Could seriously harm your life, health or ability to regain full function.
- Would subject you to severe pain without getting treatment faster than the standard appeal time frame would allow.

To file a fast appeal, call Member Services at 1-855-690-7784 (TTY 711) Monday through Friday from 7 a.m. to 7 p.m. We'll reply no later than three calendar days after we get your request.

How to file a basic appeal
To file a basic appeal, send a letter to:
Central Appeals Processing
Anthem Blue Cross and Blue Shield Medicaid
P.O. Box 62429
Virginia Beach, VA 23466-2429

You can include any other information with your request. It's best to file an appeal in writing, but you can call 1-855-690-7784 (TTY 711) to ask for one by phone. If you call to ask for an appeal, you must also send a written request within 10 calendar days of your verbal request.

We'll let you know we got your request within five calendar days. We'll send you our decision in writing no more than 30 calendar days after we got your request.

How your appeal will be handled
We'll review all the data you send even if we looked at it when we made our first decision. We'll complete a new review and won't base it on the first one. The person looking at your appeal:

- Will not have been involved in the first decision.
- Will not be a direct employee of the person who made the first decision.
- May ask for records from any doctors or providers with data about your care.

A doctor with the right clinical expertise will look at appeals about medically necessary services. They will have a license in the same or similar specialty as typically manages the medical condition, procedure or treatment under review. Any other decision about the review of medical data will be made by the right clinical staff.

You can ask to keep getting services during your appeal
To ask to keep getting services while your appeal is in review, call Member Services at 1-855-690-7784 (TTY 711). To keep getting services, all of the following must be met:

- You ask to extend benefits.
- The appeal request is filed within 10 calendar days of the mailing date on the denial notice.
- The appeal involves ending, reducing or suspending previously approved treatment or services.
- The services were ordered by an authorized provider.
- The coverage period previously authorized has not expired.

You may have to pay the costs of services, including EPSDT services, if the first decision isn't changed.

If you don't agree with the appeal decision

If you've gone through our entire internal appeal process and you still disagree with our decision, you can ask for a state fair hearing.

To ask for a state fair hearing, send a letter asking for a state fair hearing to CHFS within 120 days of the date on the final decision notice from us. Send your letter to:
Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality and Outcomes
275 East Main Street, 6C-C
Frankfort, KY 40621 0001
Telephone: 1-800-372-2973 (TTY1-800-627-4702)

Be clear about what action or decision you want to appeal. Include a copy of the notice about the action if you have it. Be sure to sign the letter.

After you file your appeal, you'll be told the date, time and place of the scheduled state fair hearing. Hearings can often be done by phone.

A Hearing Officer at the Administrative Hearing Branch (AHB) will conduct the state fair hearing. The Hearing Officer will report the results of the hearing to you, us and CHFS.

Translation and interpreter services

Please call us at 1-855-690-7784 if you:

- Need help translating any materials in a language other than English
- Need to find a doctor that speaks a language other than English
- Need written materials in an alternate format

These services are at no cost to you. If you're deaf or hard of hearing, call 711.