- Fill out and sign a new form if you wish to make changes in your living will.

Your PCP will require you to sign the Acknowledgement of Patient Information on Advance Directives form. Your signed form, along with your advance directive, will be kept on file with your medical record.

Right to object

Nevada law says your PCP and other providers, individually and/or institutionally, have the right to object to the request you make in your advance directive. You can find the law in the Nevada Revised Statutes Annotated Section 449.628.

Individual and institutional objection

An individual objection is when your individual PCP or other providers treating you will not honor your advance directive on the basis of their conscience (beliefs).

An institutional objection is when an entire institution, like a hospital or health system, will not honor your advance directive for reasons of conscience (beliefs). The range of medical conditions that may be objected to by individual and institutional providers could be different from provider to provider. Be sure to ask your PCP and other providers if they have objections to the requests you have included in your advance directive.

If your PCP or other provider objects to the request for care you make in your advance directive, you have the right to select another PCP or provider who will honor your request. Please call Member Services at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time for help.

If you have a grievance about your advance directive, contact Member Services or file your grievance with DHCFP at:

Division of Health Care Financing and Policy
1100 E. William St., Suite 101
Carson City, NV 89701
1-775-684-3676

GRIEVANCES AND MEDICAL APPEALS

If you have any questions or concerns about your Anthem benefits, please call Member Services at 1-844-396-2329 (TTY 711). You can also write to us.

Grievances

If you have a problem with our services or network providers, we would like you to tell us about it. Please call Member Services and we will try to solve your problem on the phone.

If we can't take care of the problem when you call us, you can file a grievance. You can:

- Write a letter to us and include information, such as:
  - The date the problem happened.
  - The names of people involved.

  - Details about the problem.
- File a grievance on the phone.
- Ask Member Services for help with writing a letter; include information such as the date the problem happened and the people involved.
- Send your letter to:

  Quality Management Department
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  Desert Canyon, Building 9
  9133 W. Russell Road
  Las Vegas, NV 89148

When we get your call or letter, we will:

1. Send you a letter within five calendar days to let you know we received your grievance.
2. Look into your grievance in a timely manner.
3. Send you a letter within 90 calendar days of when you first told us about your grievance; the letter will tell you what we decide.

Second level grievance review

You may file a second level grievance review if you're not happy with our decision, and your grievance is about:

- Your ability to receive benefit coverage.
- Access to care.
- Access to services.
- Payment for services.

Ask us for a second level grievance review in writing within 90 calendar days of the date on the original grievance resolution letter we sent you. Mail your second level grievance review request to the same address that you sent your initial grievance request. We'll send you a letter within five calendar days to let you know we got your request. Someone at a higher level than the reviewer who looked at your initial grievance request will look at your second level request. We'll send you a letter with our decision within 30 calendar days. The second level grievance review is the final level of review for grievances.

Appeals

Medical appeals

There may be times when Anthem says we will deny, end or reduce a service we approved. We may also say we won't pay for all or part of the care your provider asked for. If we decide to deny the care a provider asked for, or to end or reduce a service you're currently approved to get, we'll send you a letter called a Notice of Action.

For standard approval requests, Anthem has 14 days to respond and either approve or deny the service request.

For expedited (rushed) approval requests, when you need a quick response, Anthem has 72 hours or less to respond and either approve or deny the service request. If Anthem is reducing or ending a previously authorized service, we must send you a Notice of Action at least 10 days before the date we plan to reduce or end the covered service.

If Anthem sends you a Notice of Action, you can appeal the decision. Your provider can appeal our decision for you if he or she has your written permission.

A medical appeal is when you ask us to look again at the care we said we wouldn't pay for. You must file for a medical appeal within 90 calendar days from the date on our first denial letter. A medical appeal can be filed by:

- You.
- A person helping you.
- Your PCP or the provider taking care of you at the time.

If you want your PCP or provider to file an appeal for you, he or she must have your written permission, unless you are asking for an expedited appeal.

To continue receiving services we have already approved and are now denying, you or your provider must complete a Request to Continue Benefits during an Appeal or Fair Hearing form and return it to us on or before the later of:

- 10 calendar days after we mail the denial notice.
- The date the notice says your service will end.

You can appeal our decision in two ways:

1. Call us
   - Call Member Services and ask to appeal.
   - Let us know if you want someone else to help you with the appeal process, such as a family member, friend, your PCP or the provider taking care of you at the time.

   If you call us, we will:
   - Send you a Request for Appeal Review form. **You must complete and sign this form and return it to us within 10 calendar days.**
   - Send you a letter within five calendar days from when we get your signed form to let you know we got your request for an appeal.

     If you are asking for an expedited appeal, you don't need to send us any documents in writing. See the section called **Expedited Appeals** for details.
2. Write us
   - Send us a letter letting us know the care you are looking for and the people involved.

- Have your doctor send us your medical information about this service to:

  Medical Appeals
  Anthem Blue Cross and Blue Shield Healthcare Solutions
  P.O. Box 62429
  Virginia Beach, VA 23466-2429
  Fax: 1-888-235-9334

You or the person filing the appeal on your behalf can present information about your appeal either in writing or in person.

When we get your letter, we will send you a letter within five calendar days. The letter will let you know we got your request for appeal.

After we receive your appeal:
- A different provider than the one who made the first decision will look at your appeal.
- We will send you and your provider a letter telling you our decision within 30 calendar days from when we get your appeal.

We'll tell you and your provider how to find out more about the decision. We'll tell you your rights to request a state fair hearing if you aren't happy with our decision. You may also request a copy (free of charge) of the documents used to make the appeal decision, including your medical records and guidelines.

If we need more information about your appeal:
- We may ask for medical records to help us make a decision. You, your PCP or the provider giving you care must forward the records to us within seven calendar days.
- Upon state approval or your request, we may extend the appeal process for 14 calendar days if it is in your best interest.
- If the state approves our extension request, we will let you — or the person you asked to file the appeal for you — know in writing the reason for the delay.

You may ask us to extend the process if you know more information that we should consider.

After you have completed the Anthem appeal process, you may ask for a state fair hearing. See the section **Fair hearings** for more details.

Expedited appeals

You or the person you ask to file an appeal for you can request an expedited appeal. You can request an expedited appeal if you or your provider feels that taking the time for the standard appeals process could seriously harm your life or your health.

You or your provider can request an expedited appeal in two ways:
1. Call Member Services toll-free at 1-844-396-2329 (TTY 711), Monday through Friday from 7 a.m. to 7 p.m. Pacific time.

2. Mail a letter to:

   Member Appeals
   Anthem Blue Cross and Blue Shield Healthcare Solutions
   Desert Canyon, Building 9
   9133 W. Russell Road
   Las Vegas, NV 89148

When we get your letter or call, we will send you a letter with our decision within 72 hours.

If you have more information you'd like us to look at, you must get it to us right away (within one or two days). If we need more information about your appeal:

- Upon state approval, we may extend the appeals process for 14 days.
- If the state approves our extension request, we will let you know in writing the reason for the delay.

You may also ask us to extend the process if you have more details that we should review.

If we don't agree that your request for an appeal should be expedited, we'll:

- Call you right away.
- Send you a letter within two calendar days to let you know how the decision was made, and that your appeal will be reviewed through the standard review process of 30 calendar days.

If the decision on your expedited appeal upholds (agrees with) our first decision and we will not pay for the care your doctor asked for, we'll call you and send you a letter. This letter will:

- Let you know how the decision was made.
- Tell you about your rights to request an expedited state fair hearing.

Provider payment appeals

If you receive a service from a provider and we don't pay for that service, you may receive a notice from Anthem called an Explanation of Benefits (EOB). **This isn't a bill.** The EOB will tell you:

- The date you received the service.
- The type of service.
- The reason we can't pay for the service.

If you receive an EOB, you don't need to call or do anything at that time, unless you want to appeal the decision.

A payment appeal is when your provider asks Anthem to look again at the service we said we wouldn't pay for. Your provider must ask for a payment appeal within 90 calendar days of receiving the EOB.

Payment appeals must be submitted in writing by your provider.

Fair hearings

You have the right to ask for a fair hearing from the state after the Anthem appeal process has been exhausted. You may ask for a fair hearing within 120 calendar days from the date of the appeal denial letter.

You can ask for a fair hearing by sending the Member State Fair Hearing form we sent you with the denial notice or a letter asking for a state fair hearing with the Anthem denial notice to:

Nevada Division of Health Care Financing and Policy Hearings
1100 E. William St., Suite 102
Carson City, NV 89701

If you have any questions about your rights to request a fair hearing, call Anthem Member Services. If you have questions regarding the fair hearing, you may call the hearings supervisor in the Las Vegas area at 1-702-486-3000, ext. 43604; or the Carson City area at 1-775-684-3604. You may also call toll-free 1-800-992-0900, ext. 43604.

If you ask for a fair hearing, you will get a letter from the state telling you the date and time of the hearing preparation meeting. The hearing preparation meeting will be held by phone, and you can explain why you disagree with the decision made by Anthem. If you proceed to a fair hearing, you must attend the fair hearing in person unless you get the hearing officer's consent to attend by phone. You don't have to pay any costs to take part in the hearing.

Continuation of benefits

You may ask Anthem to continue to cover your benefits during the appeal or fair hearing process. Call Member Services or send us the form you got with your Notice of Decision. The request to continue benefits applies to inpatient stays, outpatient services, or pharmacy benefits approved by Anthem that you still get now.

Your first request to continue benefits may be verbal. But you must also ask in writing. If you want to keep getting benefits, please fill out the Request to Continue Benefits during an Appeal or a Fair Hearing form and return it to:

Appeals Department
Anthem Blue Cross and Blue Shield Healthcare Solutions
Desert Canyon, Building 9
9133 W. Russell Road
Las Vegas, NV 89148

To continue services during the appeal or fair hearing:

- You must request to continue benefits within 10 calendar days of the notice of action or by the effective date of the reduction, suspension or termination of the service.
- Any previously authorized course of treatment must have ended or been suspended or reduced.
- Services must have been ordered by an authorized provider.
- The coverage period of the original approval must still be in effect.

We must continue coverage of your benefits until:

- You withdraw the appeal.
- 10 days from the date of our first decision if you haven't requested a fair hearing.
- A fair hearing decision is reached and isn't in your favor.
- Authorization expires or your service limits are met.

Anthem will pay for services you get during the time your benefits were continued until a final decision is made. **You may have to pay for the cost of any continued benefit if the final decision isn't in your favor.**

If a decision is made in your favor as a result of your appeal or fair hearing, we'll authorize and pay for the services we denied coverage of before.

OTHER INFORMATION

If you move or your family size changes

If you're a Medicaid member, you must contact your welfare caseworker as soon as you move to report your new address or if your family size changes. Please find the number to call under the section **Important phone numbers**.

If you're a Nevada Check Up member, you should call Nevada Check Up when your family size changes or you move to a new address. Please find the number to call under the section **Important Phone Numbers**.

Once you call the state, you should then call Anthem Member Services. If you move out of the service area, you will continue to get health care services through us until you are disenrolled. You must call Anthem before you can get any services in your new area unless it is an emergency.

How to renew your Medicaid or Nevada Check Up benefits on time

Keep the right care. You need to renew your benefits every 12 months. If you don't, you could lose your Medicaid or Nevada Check Up benefits, even if you still qualify.

If you're a Nevada Medicaid member, the Nevada Division of Welfare and Supportive Services (DWSS) will send you a letter telling you it is time to renew your Medicaid benefits. You will receive a renewal package about two months before the date you need to renew your benefits. You can return the packet via mail, or renew online at www.dwss.nv.gov.

If you're a Nevada Check Up member, the Nevada Division of Health Care Financing and Policy (DHCFP) will send you a letter telling you it is time to renew your Nevada Check Up benefits. You will receive a renewal package about two months before the date you need to renew your benefits.

If you don't renew your eligibility by the date in the letter, you'll lose your health care benefits. Your DWSS or welfare caseworker can answer your questions about renewing your benefits. We want you to keep getting your health care benefits from us as long as you still qualify. Your health is very important to us.

If you're no longer eligible for Medicaid or Nevada Check Up

You'll be disenrolled from Anthem if you're no longer eligible for Medicaid or Nevada Check Up benefits. If you're ineligible for Medicaid or Nevada Check Up for two months or less and then become eligible again, you'll be re-enrolled in Anthem. If possible, you'll be given the same PCP you had when