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Appeal process for SmartHealth members

What is an appeal?
An appeal is a written request by you or your authorized representative (For example, your provider) to dispute the adverse decision related to your coverage. Before submitting an appeal, contact the Smarthealth Customer Service team at 888-492-6811 to review any adverse coverage determinations. This team may be able to resolve your issue quickly outside of the formal appeal process. If not, they will advise you of your appeal rights.

To avoid having to submit an appeal, ensure you have a prior authorization or benefit elevation, before services are rendered. Find services that require an authorization and benefit elevation requirements on mysmarthealth.org.

Different types of appeals:

- **Appeal of a pre-service claim**:
  - A prior authorization (PA) request for a service on the PA list is denied *before* services are rendered.
- **Appeal of a post-service claim:**
  - Service(s) have been rendered and you receive an adverse benefit determination related to your coverage.
- **Appeal of a benefit elevation:**
  - A pre-service request for benefit elevation *before* services are rendered is denied.
  - A post-service retrospective request *after* services are rendered.

How to submit an appeal:

1. Complete and submit an appeal form along with any supporting documentation to the address below.

Pre-service appeals
eQHealth Solutions
Fax: (469) 212-1579
Mail: 1431 Greenway Suite 500
Irving, TX 75038

Post-service and benefit elevation appeals
SmartHealth appeals
Fax: (586) 238-4363
Mail: PO Box 321125
Detroit, MI 48232

2. Supporting documentation may include the following: Copy of the claim, explanation of payment (EOP) and/or explanation of benefit (EOB), adverse decision letter, a letter from your provider and applicable medical records**. Accurate and complete preparation of your appeal is important for a timely and thorough review.**

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How long do I have to submit my appeal?
In most cases you have **180** days to appeal the first adverse benefit determination.

Retrospective authorization: If you received services that require prior authorization and no authorization was obtained, you have **30** days from the date of service to appeal in the following extenuating circumstances:

- The provider and/or facility was unable to identify from which health plan to request an authorization. You were not able to tell the provider about your insurance coverage, or the provider verified different insurance coverage prior to rendering services.
- You required immediate medical services and the provider was unable to anticipate the need for a prior authorization immediately before or while performing a service.
- You were discharged from a facility and insufficient time existed for institutional or home health care services to receive approval prior to the delivery of the service.

In each case, the provider was unable to request prior authorization for services as required by the provider's contract and the member's coverage agreement. All retrospective review requests must include the reason/explanation for not submitting an authorization request prior to rendering services.

After 30 days from the date of the service, the initial decision is considered final and may no longer be appealed.

Benefit elevation: Approval is required in order to obtain a benefit elevation, please refer to the medical plan for requirements. If you receive services from a National Network (Tier 2) or Out-of-Network (Tier 3) provider and believe you meet the requirements for a benefit elevation, you may appeal following the appeal process listed above.

After the deadlines listed above, the initial decision is considered final and may no longer be appealed.

How long will it take my appeal to be reviewed?

- **Pre service:** 30 days for a standard request and 72 hours for urgent requests.
- **Post service and benefit elevation:** 60 days, however most are reviewed within 30 days.

You will receive an appeal decision in writing. If you disagree with the decision, you may file a second appeal within **60** days after receiving the decision.

Smarthealth Advisory Committee
Fax: (586) 238-4363
Mail: SmartHealth Advisory Committee
PO Box 321125
Detroit, MI 48232

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Who will review my appeal?
A qualified person/committee who was not involved in the initial decision will review your appeal.

With questions, call Customer Service at 888-492-6811.
This is a brief overview of claim denials and appeals, which is subject to change. To resolve any conflict between this overview and the Summary Plan Description, you should consult the plan document, which will prevail over both this overview and the Summary Plan Description. For further details about plan benefits, please contact customer service at the number shown on the back of your ID card, or view the official summary plan description at mysmarthealth.org.

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