Appeals Form

Appeals Procedure

For the purposes of this section, any reference to "you", "your", or Insured Person also refers to a representative or provider designated by you to act on your behalf, unless otherwise noted.

The company has a two-step appeals/grievance procedure for coverage decisions. To initiate an appeal, you must submit a request for an appeal/grievance in writing within 180 days of receipt of a denial notice. You should state the reason why you feel your appeal or grievance should be approved and include any information supporting your appeal/grievance. You may send it to the address above, or go to the website where you can complete an appeal form and submit it to us.

Level One Appeal

If you are not satisfied with an administrative, eligibility, rescission of coverage, denial or reduction of benefit or if a health care determination for pre-service or current care coverage has been denied; you or your appointed representative has the right to file an appeal or a grievance within 180 days.

Your appeal/grievance will be reviewed and the decision made by someone not involved in the initial decision. Appeals involving Medical Necessity, clinical appropriateness, or experimental and investigational will be considered by a health care professional.

For Level One Appeals, we will respond in writing or electronically with a decision within fifteen calendar days after we receive an appeal for a required pre-service or concurrent care coverage determination (decision). We will respond within thirty calendar days after we receive an appeal for a post service coverage determination. If more time or information is needed to make the determination, we will notify you in writing or electronically to request an extension of up to fifteen calendar days and to specify any additional information needed to complete the review.

You may request that the appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health, ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; (2) or your appeal involves non-authorization of an admission or continuing inpatient stay. Our Medical Review Agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, we will respond within seventy-two hours, followed up in writing or electronically within (5) five days.

Level Two Appeal

If you are dissatisfied with our level one appeal decision, you may request a second review. To start a Level Two Appeal, follow the same process required for a level one appeal.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. Anyone involved in the prior decisions may not vote on the committee. For appeals involving Medical Necessity, clinical appropriateness, or being experimental or investigational, the Committee will consult with at least one Physician reviewer in the same or similar specialty as the care under consideration, as determined by our medical review agent.

For level two appeals we will acknowledge in writing or electronically that we have received your request and schedule a Committee review. For required pre service and concurrent care coverage determinations, the Committee review will be completed within fifteen calendar days. For post service claims, the Committee review will be completed within thirty calendar days. If more time or information is needed to make the determination, we will notify you in writing to request an extension of up to fifteen calendar days and to specify any additional time needed by the committee to complete the review. You will be notified in writing of the decision within five working days of the meeting, and within the Committee review time frames.

You may request that the level two appeal process be expedited if, (a) the time frames under this process would seriously jeopardize your life, health, ability to regain maximum function or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services; (b) or your appeal involves non-authorization of an admission or continuing inpatient stay. Our medical review agent in consultation with the treating Physician will decide if an expedited review is necessary. When an appeal is expedited, we will respond within 72 hours, followed up in writing or electronically within (5) five calendar days.

Independent Review Procedure

If you are not satisfied with the final adverse benefit determination decision of the level two appeal review regarding your Medical Necessity, clinical appropriateness, or experimental or investigational issue, you may request that your appeal be referred to an Independent Review Organization.

The Independent Review Organization is composed of persons who are not employed by us or our administrator or any of our affiliates. A decision to use this external level of appeal will not affect the claimant's rights to any other benefits under the plan.

There is no charge for you to initiate this independent review process. The Company will abide by the decision of the Independent Review Organization.

In order to request a referral to an Independent Review Organization, certain conditions apply. The reason for the denial must be based on a Medical Necessity or clinical appropriateness determination or because it is considered to be experimental or investigational by our medical review agent. Administrative, eligibility, or benefit coverage reductions or exclusions are not eligible for appeal under this process.

To request a review, you must notify the Appeals Coordinator within 180 days of your receipt of The Company's final adverse benefit determination. The Company will then forward the file to the Independent Review Organization.

The Independent Review Organization will render an opinion within 30 days, when requested and when a delay would be detrimental to your condition, as determined by your physician and the external review agent, the review shall be completed within 72 hours upon receipt of required information.

GBG must receive an Appeals Form within 180 days of receiving your processed claim, denial letter or denial of Pre-authorization. Upon appeal, the member will pay any fees associated with the request of medical records. The Appeals Committee will review your information and provide a written response within 30 calendar days of receipt. Emergency reviews will be accelerated at the discretion of the Appeals Committee. If a decision is made to alter the initial decision and issue additional payment, you may be notified of the payment adjustment through an Explanation of Benefits (EOB). If a decision is made to uphold our initial decision, you will be notified in writing.

Copies of the following supporting documents are required:

- Original claim
- Explanation of Benefits (EOB)
- Any and all letters/emails regarding this claim for benefits
- Any additional supporting medical documentation or reports
- Any other document that you wish to include in this review

Please send completed claim form and supporting documents to Global Benefits Group:

- **Email:** customerservice@gbg.com
- **Mail:** 27422 Portola Parkway, Suite 110, Foothill Ranch, CA 92610 USA
- **Fax**: +1.949.271.2330

A. PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:
Claim Number(s):		
Date(s) of Service:		
Policy #:	GBG ID #:	
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)		
Address:		
Postal Code:	Country:	
Phone:	Fax:	
Email:		

B. APPEAL CORRESPONDENT (If different from Section A.)

Relationship to Patient:	Contracted Provider? ☐ Yes ☐ No

NOTE: If you are not the member, claimant or Provider of Service, please attach documentation showing you have legal authorization/rights to appeal on the Patient's behalf, such as, but not limited to, a signed and dated letter of authorization, a legal power of attorney document, etc.

Office/Facility Name:	
Address:	
Postal Code:	Country:
Phone:	Fax:
Email:	

C. APPEAL

Is this an appeal for a service that has NOT been rendered that REQUIRES AUTHORIZATION? ☐ Yes ☐ No

Please check off the selection that best describes your appeal:

☐ Bundling Denial

☐ Maximum Reimbursable Amount

☐ Timely Claim Filing (without Proof)

☐ Medical Necessity

☐ Provider Fee Schedule

☐ Experimental/Investigational Procedure

☐ Inpatient Facility Denial (Level of Care, Length of Stay)

☐ Benefit Administration (i.e. co-payment, deductible, etc.)

☐ Contract Language

☐ Benefit Exclusion or Limitation

☐ Other:_____

Please provide a summary of your request and include any details that you wish to have reviewed. Please indicate the specific reason for the request for review. If more space is needed, attach separate page(s) which must be signed and dated.

D. AUTHORIZATION

Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

Name:

Signature:

By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.

Date:

Fair Processing Notice

The GBG Group includes insurance companies, brokering and management companies, as well as assistance and operations companies. We respect your privacy and we are all committed to protecting your personal information.

Our privacy policy tells you about your privacy rights and how the law protects you. This includes information on how we collect and then process your personal information. Our privacy policy is located on our website at https://www.gbg.com/#/AboutGBG/PrivacyPolicy and we would advise you to read the policy so you understand your rights and your personal data use by the GBG Group