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 file 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 email address below or go to our 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 treatments 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 twenty-five 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, OR (2) 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 file a Level Two Appeal. To do so, follow the same process required for a Level One Appeal. Level Two Appeals must be submitted within twenty-five calendar days of receiving a Level One Appeal decision.

Most requests for a second review will be conducted by the Appeals Committee, which consists of at least three people. 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 twenty-five calendar days.

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; OR (b) 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

Copies of the following supporting documents are required for all appeals:

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

Please send all documents to TieCare International:

- **Email:** customerservice@tiecare.com
- **Fax**: +1.949.271.2330

A. INSURED INFORMATION

Last Name:	First Name:	Middle Initial:
Claim Number(s):		
Date(s) of Service:		
Policy #:	Member 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 Insured:	Contracted Provider? ☐ Yes ☐ No

NOTE: If you are not the insured, claimant or Provider of Service, please attach documentation showing you have legal authorization/rights to appeal on the Insured'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:

Privacy Notice

The TieCare International group of companies includes brokering and management companies, as well as assistance and administration 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 www.totalscholasticsolutions.com/privacy-policy and we would advise you to read the policy so you understand your rights and your personal data used by the TSS Group.