Enrollee Information

ENROLLEE INFORMATION

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The following section provides an overview on FHW enrollee rights and responsibilities, appeals and grievances and resources available to FHW providers.

Enrollees Rights and Responsibilities:

I. Statements of Members' Rights and Responsibilities

Fallon Health Weinberg (FHW) states the organization's commitment to treating members in a manner that respects their rights as well as its expectations of members' responsibilities in its Statements of Members' Rights and Responsibilities, which include at least the following:

Enrollees' Rights

A. Each enrollee has the right to be treated with respect and with consideration of their dignity and privacy

B. Each enrollee has the right to be treated fairly regardless of their race, religion, gender, ethnicity, age, disability or source of payment.

C. Each enrollee has the right to have their treatment and other member information kept private and confidential. Only where permitted by law, may records be released without the enrollee's permission.

D. Each enrollee has the right to easily access care in a timely fashion.

E. Each enrollee has the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the Enrollee's condition and ability to understand.

F. Each enrollee has the right to share in developing their plan of care.

G. Each enrollee has the right to receive interpretation services at no cost to the enrollee, including the right to receive information in a language they can understand. Information is available in alternate formats upon request.

H. Each enrollee has the right to receive information about FHW, its practitioners, programs, services, clinical guidelines and role in the treatment process.

I. Each enrollee has the right to receive information about clinical guidelines used in providing and managing their care.

J. Each enrollee has the right to ask their provider about their work history and training.

K. Each enrollee has the right to give input on the FHW's Rights and Responsibilities policy.

L. Each enrollee has the right to know about advocacy and community groups and prevention services.

M. Each enrollee has the right to request certain preferences in a provider.

N. Each enrollee has the right to have provider decisions about their care made on the basis of treatment needs.

O. Each enrollee has the right to be furnished health care services in accordance with Federal and State laws that pertain to enrollee rights.

P. Each enrollee has the right to participate in decisions regarding his or her health care, including the right to receive a second medical opinion, and the right to refuse treatment.

Q. Each enrollee has the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in Federal regulations on the use of restraints and seclusion.

R. Each enrollee has the right to file a complaint/grievance about FHW, a provider or the care received.

S. Each enrollee has the right to file an appeal about a FHW action or decision.

T. Each enrollee has the right to request and receive a copy of his or her medical records.

U. Each enrollee is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way FHW and its providers treat the enrollee.

V. Each enrollee has the right to receive written information on advanced directives and their rights under State law.

W. Each enrollee has the right to decline participation or withdraw from programs and services.

X. Each enrollee has the right to know which staff members are responsible for managing their services and from whom to request a change in services.

Enrollees' Responsibilities

A. Each enrollee has the responsibility to treat those giving them care with dignity and respect.

B. Each enrollee has the responsibility to give providers and FHW information they need. This is so providers can deliver quality care and FHW can deliver appropriate service.

C. Each enrollee has the responsibility to ask their providers questions about

their care. This is to help them understand their care.

D. Each enrollee has the responsibility to follow their treatment plan. The plan of care is to be agreed upon by the enrollee and provider.

E. Each enrollee has the responsibility to follow the agreed upon medication plan.

F. Each enrollee has the responsibility to tell their providers and primary care physician about medication changes, including medications given to them by others.

G. Each enrollee has the responsibility to keep their appointments. Enrollees should call their provider(s) as soon they know they need to cancel visits.

H. Each enrollee has the responsibility to let their provider know when the treatment plan is not working for them.

I. Each enrollee has the responsibility to report abuse and fraud. Callers may choose to remain anonymous. All calls will be investigated and remain confidential.

J. Each enrollee has the responsibility to openly report concerns about quality of care.

II. Provider Education

The Statements of Member Rights and Responsibilities are distributed to practitioners in FHW's Provider Manual and available on the FHW website. Copies are also readily available to practitioners upon request.

FHW does not restrict providers from advising or advocating on their patients' behalf.

III. Member Education

The Statements of Rights and Responsibilities are distributed to new and existing members in FHW's Evidence of Coverage manual, member newsletter and website. Copies are also readily available to members, authorized representatives, customer organizations and the general public upon request.

FHW recognizes the specific needs of members and maintains a mutually respectful relationship with members.

IV. Review and Revisions

The Statements of Rights and Responsibilities are revised when necessary to fulfill requirements of CMS, the state's statutes, or to satisfy public concern in specific issues.

Review and revisions to the Statements are the responsibility of FHW's Quality Programs Manager to ensure compliance with external regulatory agencies and comply with FHW's policy regarding Member Rights and Responsibilities.

Enrollee Member Appeals and Grievances Process

Fallon Health Weinberg (FHW) supports the rights of Enrollees and providers acting on the Enrollee's behalf to file a grievance about plan policies, providers or services and to appeal an adverse determination made by the plan regarding their coverage or service. This section describes the Fallon Health Weinberg processes in place to support the filing of such and the procedures for providers to advocate on the Enrollee's behalf or to guide Enrollees regarding their rights to request an appeal or grievance.

CUSTOMER SERVICE

The Fallon Health Weinberg Customer Service Department is available to assist Enrollees and Enrollee prospects with their service needs. The direct telephone number is:

FHW HMO SNP: 1-855-561-7247 or 716-810-1892
FHW PACE: 1-855-665-1113 or 716-810-1895
FHW MLTC: 1-866-882-8185 or 716-250-3100

TTY access for those who are hearing impaired is TRS relay 711. The Customer Service Department assists customers with routine inquiries such as questions regarding benefits, ID card requests and PCP selections (see section on "Access services").

The Customer Service staff can also assist Enrollees with more complex needs such as administrative discrepancies and difficulties with obtaining access to care. More complex cases are documented to ensure follow-through and a record for future reference. On some occasions, you may be contacted by a member of the Customer Service staff for assistance with servicing an Enrollee.

The Customer Service staff also works closely with the Fallon Health Weinberg Appeals and Grievances Department to make sure that Enrollees wishing to file a grievance or appeal are handled in an appropriate fashion.

The Customer Service Department can also assist you with urgent Enrollee eligibility questions. All routine eligibility questions that cannot be resolved by reviewing your panel report should be directed to Customer Service at:

FHW HMO SNP: 1-855-561-7247 or 716-810-1892
FHW PACE: 1-855-665-1113 or 716-810-1895
FHW MLTC: 1-866-882-8185 or 716-250-3100

All routine requests will be responded to within one business day.

If you or your office staff has questions regarding prior authorization or case management claims for all your Fallon Health Weinberg Enrollees, you can contact the Provider Service Line at 1-855-827-2003 or 716-810-1893 to be directed to the appropriate department.

ENROLLEE APPEALS AND GRIEVANCES DEPARTMENT APPEALS AND GRIEVANCE PROCEDURES

Fallon Health Weinberg's Enrollee Appeals and Grievances Department Coordinators are available to assist Enrollees if they have grievances about plan policies, providers or services, or wish to appeal an adverse determination made by the plan regarding their coverage or service.
Coordinators are trained to assist Enrollees with their grievances and appeals in accordance with their rights and in a confidential manner. Depending on the product, the staff follows policies and procedures which protect Enrollee rights and adhere to quality standards set by the National Committee for Quality Assurance (NCQA), Medicare guidelines as defined by the Centers for Medicare & Medicaid (CMS) and all Federal and State requirements, including "New York State Department of Health"

Fallon Health Weinberg utilizes the following definitions:

> **Grievance:** An Enrollee's written or oral expression of dissatisfaction with any aspect of operations, activities or behavior of a health plan, or its providers regardless of whether remedial action is requested.
>
> **Appeal:** a request by an Enrollee to review any health plan decision to deny, terminate, suspend, or reduce services. An Enrollee may appeal a delay in the health plan providing or arranging for a Covered Service.

The Enrollee Appeals and Grievances Department has dedicated staff to promote Enrollee retention, to make every effort to satisfy Enrollee expectations and strengthen customer confidence. When any Fallon Health Weinberg Enrollee is dissatisfied with plan policy, plan providers or services, they have a right to file a grievance. Enrollee Appeals and Grievances coordinators work with Fallon Health Weinberg providers or management staff to review and resolve the grievance. The standard for resolving all Enrollee grievances is 30 calendar days.

All grievance data is tracked to report trends, corrective action plans and improvement measures to Fallon Health Weinberg.

ENROLLEE APPEALS AND GRIEVANCES

When plan Enrollees are dissatisfied with the outcome of a plan review regarding denial

of coverage or services, they have the right to appeal the decision. The Enrollee Appeals and Grievances staff coordinates the plan's Enrollee appeals procedure for Fallon Health Weinberg.

GRIEVANCES

A grievance is the type of complaint an Enrollee may make if he/she has any other type of problem with Fallon Health Weinberg or one of our plan providers. If the grievance is made by someone other than the Enrollee, the Enrollee must submit a document appointing him or her to act on their behalf. The Enrollee, or the person you choose to represent him/her, would file a grievance if there was a problem with situations such as:

Waiting times when filling a prescription
The way the network pharmacist or others behave
Being able to reach someone by phone
Getting the information needed
The cleanliness or condition of a network pharmacy
Whenever we do not provide a fast decision about an initial request for a service or a request to appeal Fallon Health Weinberg's denial of a service.

There are two kinds of grievances you can file:

1. Expedited (72 hours)—An Enrollee may file an expedited grievance whenever Fallon Health Weinberg does not provide a fast decision about an initial request for a service or a request to appeal a denial of a service.

2. Standard (30 days)—An Enrollee may file a standard grievance. Fallon Health Weinberg will contact the Enrollee within 30 calendar days of receiving the grievance to discuss a possible resolution to the concern.

FHW HMO SNP:
Expedited Grievance
Call the Fallon Health Weinberg Appeals & Grievances Department at:

1-800-333-2535 ext. 69950 (TTY users, please call TRS Relay 711).
Monday through Friday, from 8 a.m. to 6 p.m. (Expedited grievances can be made and are processed 24 hours a day, seven days a week by leaving a voice message.)
Fax: 716-810-1911

Standard Grievance
Call the Fallon Health Weinberg Member Appeals & Grievances Department at the number below or, send a letter including all details of your grievance to:

Fallon Health Weinberg
10 Chestnut St. Worcester, MA 01608
1-800-333-2535 ext. 69950, Monday through Friday, from 8 a.m. to 6 p.m.
Fax: 716-810-1911

MLTC and PACE:
Expedited Grievance:

Call the Fallon Health Weinberg Grievances Department at the number below or, send a letter including all details of your grievance to:

Fallon Health Weinberg
461 John James Audubon Parkway,
Amherst, NY, 14228

FHW PACE: 1-855-665-1113 or 716-810-1895, Monday through Friday, from 8 a.m. to 6 p.m.

FHW MLTC: 1-866-882-8185 or 716-250-3100, Monday through Friday, from 8 a.m. to 6 p.m.

(TTY users, please call TRS Relay 711).
(Expedited grievances can be made and are processed 24 hours a day, seven days a week by leaving a voice message). Fax (FHW PACE and MLTC): 716-250-3160,

Standard Grievance
Call the Fallon Health Weinberg Grievances Department at the number below or, send a letter including all details of your grievance to:

Fallon Health Weinberg
461 John James Audubon Parkway,
Amherst, NY, 14228

FHW PACE: 1-855-665-1113 or 716-810-1895, Monday through Friday, from 8 a.m. to 6 p.m.
FHW MLTC: 1-866-882-8185 or 716-250-3100, Monday through Friday, from 8 a.m. to 6 p.m.

(TTY users, please call TRS Relay 711).

Fax (FHW PACE and FHW MLTC): 716-250-3160

A Fallon Health Weinberg Enrollee Services Representative will let you know that Fallon Health Weinberg received a letter within 24 to 48 hours of receipt. Every reasonable attempt will be made to resolve the complaint within 30 days. All grievances submitted in writing will be responded to in writing.

Grievances made orally will be responded to orally and in writing. All quality of care grievances will be responded to in writing and will include information of the rights to file a written complaint to the Quality Improvement Organization.

APPEALS

MLTC Appeals Process:

What is an Action?
When Fallon Health Weinberg denies or limits services requested by you or your provider; denies a request for a referral; decides that a requested service is not a covered benefit; reduces, suspends or terminates services that we already authorized; denies payment for services; doesn't provide timely services; or doesn't make grievance or appeal determinations within the required timeframes, those are considered plan "actions". An action is subject to appeal. (See How do I File an Appeal of an Action? below for more information.)

Timing of Notice of Action
If we decide to deny or limit services you requested or decide not to pay for all or part of a covered service, we will send you a notice when we make our decision. If we are proposing to reduce, suspend or terminate a service that is authorized, our letter will be sent at least 10 days before we intend to change the service.

Contents of the Notice of Action

- Any notice we send to you about an action will:
- Explain the action we have taken or intend to take;
- Cite the reasons for the action, including the clinical rationale, if any;
- Describe your right to file an appeal with us (including whether you may also have a right to the State's external appeal process);
- Describe how to file an internal appeal and the circumstances under which you can request that we speed up (expedite) our review of your internal appeal;
- Describe the availability of the clinical review criteria relied upon in making the decision, if the action involved issues of medical necessity or whether the treatment or service in question was experimental or investigational;
- Describe the information, if any, that must be provided by you and/or your provider in order for us to render a decision on appeal. If we are reducing, suspending or terminating an authorized service, the notice will also tell you

about your right to have services continue while we decide on your appeal; how to request that services be continued; and the circumstances under which you might have to pay for services if they are continued while we were reviewing your appeal.

How do I File an Appeal of an Action?

If you do not agree with an action that we have taken, you may appeal. When you file an appeal, it means that we must look again at the reason for our action to decide if we were correct. You can file an appeal of an action with the plan orally or in writing. When the plan sends you a letter about an action it is taking (like denying or limiting services, or not paying for services), you must file your appeal request within 45 calendar days of the date on our letter notifying you of the action. If you call us to file your request for an appeal, you must send a written request unless you ask for an expedited review.

How do I Contact my Plan to file an Appeal?

We can be reached by calling *800-333-2535 ext. 69950 (TTY: TRS 711)* writing to

Fallon Health Weinberg
Appeals Division
10 Chestnut Street
Worcester, MA 01608

The person who receives your appeal will record it, and appropriate staff will oversee the review of the appeal. We will send a letter telling you that we received your appeal, and how we will handle it. Your appeal will be reviewed by knowledgeable clinical staff who were not involved in the plan's initial decision or action that you are appealing.

For Some Actions You May Request to Continue Service During the Appeal Process

If you are appealing a reduction, suspension or termination of services you are currently authorized to receive, you may request to continue to receive these services while we are deciding your appeal. We must continue your service if you make your request to us no later than 10 days from our mailing of the notice to you about our intent to reduce, suspend or terminate your services, or by the intended effective date of our action, and the original period covered by the service authorization has not expired. Your services will continue until you withdraw the appeal, the original authorization period for your services has been met or until 10 days after we mail your notice about our appeal decision, if our decision is not in your favor, unless you have requested a New York State Medicaid Fair Hearing with continuation of services. (See Fair Hearing Section below.)

Although you may request a continuation of services while your appeal is under review, if your appeal is not decided in your favor, we may require you to pay for these services if they were provided only because you asked to continue to receive them while your appeal was being reviewed.

How Long Will it Take the Plan to Decide My Appeal of an Action?

Unless you ask for an expedited review, we will review your appeal of the action taken by us as a standard appeal and send you a written decision as quickly as your health condition requires, but no later than 30 days from the day we receive an appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.) During our review you will have a chance to present your case in person and in writing. You will also have the chance to look at any of your records that are part of the appeal review.

We will send you a notice about the decision we made about your appeal that will identify the decision we made and the date we reached that decision. If we reverse our decision to deny or limit requested services, or reduce, suspend or terminate services, and services were not furnished while your appeal was pending, we will provide you with the disputed services as quickly as your health condition requires.

In some cases you may request an "expedited" appeal. (See Expedited Appeal Process Section below.)

Expedited Appeal Process

If you or your provider feels that taking the time for a standard appeal could result in a serious problem to your health or life, you may ask for an expedited review of your appeal of the action. We will respond to you with our decision within 2 business days after we receive all necessary information. In no event will the time for issuing our decision be more than 3 business days after we receive your appeal. (The review period can be increased up to 14 days if you request an extension or we need more information and the delay is in your interest.)

If we do not agree with your request to expedite your appeal, we will make our best efforts to contact you in person to let you know that we have denied your request for an expedited appeal and will handle it as a standard appeal. Also, we will send you a written notice of our decision to deny your request for an expedited appeal within 2 days of receiving your request.

If the Plan Denies My Appeal, What Can I Do?

If our decision about your appeal is not totally in your favor, the notice you receive will explain your right to request a Medicaid Fair Hearing from New York State and how to obtain a Fair Hearing, who can appear at the Fair Hearing on your behalf, and for some appeals, your right to request to receive services while the Hearing is pending and how to make the request. If we deny your appeal because of issues of medical necessity or because the service in question was experimental or investigational, the notice will also explain how to ask New York State for an "external appeal" of our decision.

State Fair Hearings

If we did not decide the appeal totally in your favor, you may request a Medicaid Fair Hearing from New York State within 60 days of the date we sent you the notice about our decision on your appeal.

If your appeal involved the reduction, suspension or termination of authorized services you are currently receiving, and you have requested a Fair Hearing, you may also request to continue to receive these services while you are waiting for the Fair Hearing decision. You must check the box on the form you submit to request a Fair Hearing to indicate that you want the services at issue to continue. Your request to continue the services must be made within 10 days of the date the appeal decision was sent by us or by the intended effective date of our action to reduce, suspend or terminate your services, whichever occurs later. Your benefits will continue until you withdraw the appeal; the original authorization period for your services ends; or the State Fair Hearing Officer issues a hearing decision that is not in your favor, whichever occurs first.

If the State Fair Hearing Officer reverses our decision, we must make sure that you receive the disputed services promptly, and as soon as your health condition requires. If you received the disputed services while your appeal was pending, we will be responsible for payment for the covered services ordered by the Fair Hearing Officer. Although you may request to continue services while you are waiting for your Fair Hearing decision, if your Fair Hearing is not decided in your favor, you may be responsible for paying for the services that were the subject of the Fair Hearing.

State External Appeals

If we deny your appeal because we determine the service is not medically necessary or is experimental or investigational, you may ask for an external appeal from New York State. The external appeal is decided by reviewers who do not work for us or New York State. These reviewers are qualified people approved by New York State. You do not have to pay for an external appeal.

When we make a decision to deny an appeal for lack of medical necessity or on the basis that the service is experimental or investigational, we will provide you with information about how to file an external appeal, including a form on which to file the external appeal along with our decision to deny an appeal. If you want an external appeal, you must file the form with the New York State Department of Financial Services within four months from the date we denied your appeal.

Your external appeal will be decided within 30 days. More time (up to 5 business days) may be needed if the external appeal reviewer asks for more information. The reviewer will tell you and us of the final decision within two business days after the decision is made.

You can get a faster decision if your doctor can say that a delay will cause serious harm to your health. This is called an expedited external appeal. The external appeal reviewer will decide an expedited appeal in 3 days or less. The reviewer will tell you and us the decision right away by phone or fax. Later, a letter will be sent that tells you the decision.

You may ask for both a Fair Hearing and an external appeal. If you ask for a Fair Hearing and an external appeal, the decision of the Fair Hearing officer will be the "one that counts."

HMO SNP:

You must ask for a Level 1 Appeal within **60 days** after you get this notice. We may give you more time if you have a good reason for missing the deadline.

If you are appealing because Fallon Health Weinberg plans to reduce or stop a service you were already getting, you have a right to keep getting that service from Fallon Health Weinberg during your appeal. **If you want the service to continue, you must ask for an appeal.**

For more information about appeals, see your *Member Handbook* (you can find the information in Chapter 9).

If you want someone else to request an appeal for you:

Your provider can request the appeal on your behalf. If you want a relative, friend, attorney, or someone besides your provider to make the appeal for you, you must first complete an Appointment of Representative form. The form gives the other person permission to act for you. To get an Appointment of Representative form, call Fallon Health Weinberg at

1-800-333-2535, ext. 69950 (TTY users, please call TRS Relay 711), Monday-Friday, 8am – 6pm.

or visit the Medicare website at:
http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf *(this link takes you away from the Fallon Health Weinberg website)*. We must receive the completed Appointment of Representative form before we can review your request, if the appeal comes from someone besides you or your provider.

There are two kinds of Level 1 Appeals

1. **Standard Appeal** – must give you a written decision on a non-drug standard appeal within **30 days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed.
2. **Fast (Expedited) Appeal** – Fallon Health Weinberg must give you a decision on a fast (expedited) appeal within **72 hours** after we get your appeal request. You can ask for a fast appeal if you or your health care provider believe your health,

life or ability to regain maximum function may be put at risk by waiting up to 30 days for a decision.

We'll automatically give you a fast appeal if your health care provider asks for one for you or supports your request. If you ask for a fast appeal without support from your health care provider, we'll decide if your health requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.

How to make a Level 1 Appeal

You or your authorized representative must ask for a Level 1 Appeal within **60 days** of getting this notice.

When you make your standard or fast appeal, you should give us the following information:

- Your name
- Address
- Member number
- Primary language (need for interpreter)
- Reason for appealing
- Any evidence you want us to review, such as medical records, health care providers' letters, or other information that explains why you need the item or service. Call your health care provider if you need this information.

To ask for an appeal, call, write, or fax us, or ask your representative or doctor to ask us for an appeal.

CALL 1-800-333-2535 ext. 69950
Monday – Friday 8-6
Calls to this number are free
"Fast" appeals can be made and are processed 24 hours a day, seven days a week by leaving a voice message at this number.

TTY TRS Relay 711
"Fast" appeals can be made and are processed 24 hours a day, seven days a week by leaving a voice message at this number.

FAX 716-810-1911

WRITE Fallon Health Weinberg, Member Appeals
10 Chestnut Street
Worcester, MA 01608

What happens next?

If you asked for a Level 1 Appeal, you will get a written notice from Fallon Health Weinberg that tells you our decision about your appeal.
If we continue to deny your request for a service, you have other options:

- In some cases, we'll also automatically send your case to an independent Medicare reviewer. **If the independent Medicare reviewer denies your request, the written decision will explain your additional appeal rights.**

Contact information
If you need information or help, call us at:
1-800-333-2535 ext. 69950
Monday-Friday 8am-6pm

Other resources to help you:
Medicare: 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048)
Medicare Rights Center: 1-888-HMO-9050
PACE

How do I request an appeal?

You need to file your appeal with us in writing, by faxing, or contacting us by telephone within 60 calendar days from receiving the denial notice. We can give you more time if you have a good reason for missing the deadline. If the appeal is made by someone other than yourself, your doctor or other prescriber, you must submit a document appointing him or her to act on your behalf.

For an expedited appeal
You, your authorized representative, or your doctor or other prescriber should contact us in writing by telephone or fax at:

Fallon Health Weinberg
Member Appeals and Grievances Department

10 Chestnut St.
Worcester, MA 01608
1-800-333-2535, ext. 69950 (TRS 711)
Monday through Friday, 8 a.m. to 6 p.m.

(Expedited appeals can be made and are processed 24 hours a day, seven days a week by leaving a voice message.)
Fax: 1-716-810-1911

For a standard appeal
You, your appointed representative, or your doctor or other prescriber should mail, fax or deliver your written appeal request to:

Fallon Health Weinberg
Member Appeals and Grievances Department
10 Chestnut St.
Worcester, MA 01608
Fax: 1-716-810-1911

Support for your appeal
You are not required to submit additional information to support your request for services or payment for services already received. The plan is responsible for gathering all necessary medical information. All Fallon Health Weinberg confidentiality procedures will be adhered to throughout the appeal process. However, it may be helpful for you to include additional information to clarify or support your position. For example, you may want to include in your appeal request information such as medical records or physician opinions in support of your appeal. To obtain medical records, send a written request to your primary care physician. If your medical records from specialty physicians are not included in your medical record from your primary care physician, you may need to make a separate written request to the specialist physician(s) who provided medical services to you. The plan will provide an opportunity for you to provide additional information in person or in writing.

Who may file an Appeal
- You may file an appeal.
- A court appointed guardian or an agent under a health care proxy to the extent provided under state law.
- A non-plan provider may file a standard 30-day appeal of a denied claim if he/she completes a waiver of liability statement that says he/she will not bill you regardless of the outcome of the appeal.

If you want someone to file the appeal for you:
- Give us your name, your Medicare number and a statement that appoints an individual as your representative. (Note: You may appoint a non-plan provider.)

For example: “I (your name) appoint (name of representative) to act as my representative in requesting an appeal from the Fallon Health Weinberg and/or the Centers for Medicare & Medicaid Services regarding the plan’s denial of services or denial of payment for services.”

- You must sign and date the statement.
- Your representative must also sign and date this statement unless he/she is an attorney.
- Include this signed statement with your appeal.

Independent review of your appeal

If the appeal determination is not fully in your favor, you may request that the plan decision be reviewed by an outside agency. If your appeal is regarding a Medicare benefit, the independent agency that has been designated by the Centers for Medicare & Medicaid Services to review Medicare appeals will review your appeal.

If you are a Medicaid beneficiary:

In some cases, you may ask for a fair hearing from New York State. A member may request a Fair Hearing with regard to: the denial, suspension, termination, or reduction of a medical treatment or on services covered under the program benefits. A member may also request a Fair Hearing if they believe that Fallon Health Weinberg did not act in a timely manner with regard to services. A member may have any individual he/she selects or designates to represent them at a Fair Hearing.

A member may request a Fair Hearing in the following ways:

1. By phone, call toll free 1-800-342-3334
2. By fax, 518-473-6735
3. By internet, www.otda.state.ny/oah/forms.asp
4. By mail, Fair Hearings, NYS Office of Temporary and Disability Assistance, P.O. Box 1930, Albany, NY 12201

Medicare Peer Review Organization appeal

If you are concerned about the quality of the care you have received, you may also file a grievance with the local peer review organization, New York Peer Review Organization (PRO) Livanta at 1866-815-5440; fax 855-236-2423. Peer review organizations are groups of doctors and health professionals that monitor the quality of care provided to Medicare beneficiaries. The peer review organization review process is designed to help stop any improper practices.

If you wish to file an appeal with Medicare or Medicaid regarding denial of payment or care you have received from Fallon Health Weinberg PACE, and are not sure which agency should handle your concern, a plan representative will discuss your options with you, and assist you in forwarding your appeal or grievance to the appropriate place.