



Grievances and Appeals

This section discusses member appeals about services or payment of services. If a provider wishes to appeal related to a disagreement about the payment, or amount paid, of a claim, the provider should contact CHP's Network Services, at 523-7361.

Capital Health Plan members, their providers and their representatives have the right to make a complaint about the services they have received, or when coverage or payment for services has been denied by CHP. There is one process for Medicare Members and a separate process for all other (commercial) members. These grievance and appeal processes are regulated by the State of Florida and/or the federal government. Please review the sections below for information about these grievance and appeal processes.

Commercial members:

The first step in filing a complaint or requesting a review of CHP decision is to call the Member Services Department. A representative will gather information about the issue and attempt a resolution. If the issue cannot be resolved, the member or the authorized representative may file the complaint or grievance in writing. All written complaints are processed through CHP's grievance procedure.

The member, provider, or member representative may initiate a formal grievance by writing to CHP and explaining the circumstances of the request. (Expedited requests can be called to Member Services at 383-3311. See below for definition of "expedited.")

Mail: CHP, Grievance/Appeals Department, P.O. Box 15349, Tallahassee, FL
32317-5349.

Fax: 383-3413.

- Pre-Service Standard Requests – when a service has not yet been provided to the member. CHP makes decisions as quickly as the medical condition requires, but must make a decision within 30 calendar days of receipt of the written grievance.
- Pre-Service Expedited Requests – if a service has not yet been provided, and the member or the physician believes the timeframes of a standard review would seriously affect the member's condition, then an expedited (fast, 72-hour) grievance can be requested. The grievance must meet these criteria to be considered expedited:
 - The standard time frame would seriously jeopardize the life or health of the member, or the member's ability to regain maximum function; or
 - In the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the request.

CHP will make a determination of whether the grievance meets criteria to be heard expeditiously, and if so, will make a decision within 72 hours of the receipt of the request.

- Post-Service Requests – when a service has already been received. CHP makes a decision on coverage or payment for a service that has already taken place as quickly as possible, but within at least 60 calendar days of receipt of the written grievance.
- Independent Review – if the member is unsatisfied with CHP's decision, there are further appeal rights. The member or his or her representative has the right to request that the decision be reviewed by an outside, independent review agency. There is no cost to the member for this review. There are different independent review organizations depending upon the member's enrollment. All letters that deny a request for service or payment will include information about the next step that can be taken to further appeal.