Grand Rounds Health

Care shaped around you.™

Your Claim Status

Waited claims, denied claims and your appeal rights

Waited claims

Sometimes we need more information to process your claim. When this happens, you'll receive a letter outlining what we need to know. The letter will also indicate the timeline for submitting the requested information. If we don't receive the information within that time frame, the claim will be denied.

Common reasons for waited claims

- **Subrogation questionnaire.*** If you've had an injury due to an unsafe situation that was not your fault, you may be contacted by Meritain Health®, The Phia Group or Socrates, our subrogation vendors. You'll be asked to provide more information in order to determine whether a responsible third party is at fault and required to cover some or all of your health care expenses.
- **Coordination of Benefits.*** If your family is covered by more than one health plan, you are considered to have primary and secondary coverage. When you submit claims to your primary Meritain Health plan, it will pay benefits without considering benefits that may be provided by your secondary plan. Your Meritain Health plan will then send you an Explanation of Benefits (EOB), which you may submit with a claim form to your secondary plan.

***These items can be responded to directly by the member.**

- **More information is required from your provider**. Meritain Health may need more information in order to properly process your claim. This information can include medical records, an itemized bill or a letter of medical necessity. Please note, these are requests for your provider, but you can follow up with them to ensure the proper items are submitted on your behalf so you are not responsible for the balance of the bill.

Timely filing

It's important for you to file claims, and appeal when necessary, as quickly as possible. Claims not submitted or responded to within 12 months from the date of service will no longer be considered eligible for filing or appeal. This means you could be responsible for the full amount of the bill.

Denied claims

If your claim is denied, it's because after review the charges did not appear to be medically necessary or the particular benefits requested are not covered by your plan. If you think the denial is a mistake, you have the right to appeal.

What if I need help understanding the denial?

Still not sure why your claim was denied? We can help. Just call Meritain Health Customer Service using the number on your denial notice and we can answer any questions you might have.

Can I provide additional information about my claim?

Yes. If your claim was denied and you'd like to provide additional information to have your claim reconsidered, you have 50 days from the date of your denial notice to submit the information.

What if I don't agree with this decision?

If the decision was made not to provide or pay for a benefit or service (in whole or in part), you have the right to file an appeal.

Your appeal rights

When you receive a notice that your claim was denied, it can be difficult to understand why. If after reviewing your denied claim you still have questions, you can file an appeal. Here are a few FAQs to help you better understand your rights.

Who may file an appeal?

You or someone you name to act for you (your authorized representative) may file an appeal. You can appoint someone to file on your behalf by requesting an Appointment of Authorized Representative form at **www.meritain.com** or by calling the customer service number on the back of your ID card.

How do I file an appeal?

If you choose to file an appeal, you or your authorized representative needs to file within 180 days of the date you received the denial.

Claims appeals (including any additional information you would like to provide) should be sent in writing to:

Meritain Health
Attn: Appeals Department
P.O. Box 41980
Plymouth, MN 55441-0970

What if my situation is urgent?

Sometimes an urgent review of your claim is needed. Generally, an urgent situation is one in which your health may be in serious jeopardy. Or, in the opinion of your doctor, you may experience pain that cannot be controlled while you wait for a decision on your appeal. If your situation meets this criteria, a review will be conducted within 72 hours.

Can I request copies of information relevant to my claim?

Yes. Upon written request and free of charge, you may ask that we send you all relevant documents, information and records. You can also request the following:

- A copy of any internal rule, guideline or protocol that was used to process your claim
- An explanation of the scientific or clinical judgment that was applied to any claim denied based on medical necessity, experimental treatment or similar exclusion or limit in your plan
- Billing and diagnosis codes, if you believe there was a coding error

What happens next?

If you choose to appeal, we'll review our information and provide you with a written decision. We'll also process the appeal in accordance with your plan document and the Department of Labor regulations (if applicable).

If your appeal is denied, you may have the right to request an external review. We will include your rights and information on how to ask for an external review with the response to your appeal. This type of request must be made no later than four months after the date you receive the denial notice. You may also direct questions about your health plan or your plan administrator to Meritain Health Customer Service.

Questions? For more information call Grand Rounds at 1.855.498.4661 or visit www.grandrounds.com/cop.

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