CalOptima Health
A Public Agency
13300 Garden Grove Blvd.
Garden Grove, CA 92843
☎ 714-468-1100
TTY: 714-468-1063
caloptima.org

Appeal for Reconsideration of Denial

Instructions for Participant: Please complete this form to request an appeal of our decision to deny, defer or modify a service or payment of a service that you or your representative requested. Send the completed form to the address below. An impartial third party not involved in the initial decision-making process will review your appeal.

Date: _____

To: _____

Quality Assurance Department or designee
CalOptima Health
PACE
13300 Garden Grove Blvd
Garden Grove, CA 92843

From: _____

Name of Participant / Participant Representative/ Provider [Please print name]:
_____

Address of the person identified on the above line: _____
_____ Phone: _____

On Behalf of:

Print Participant's Name (if other than participant filing): _____

☐ ☐ ☐

As a **participant / representative / provider** (circle one) of **CalOptima Health PACE**, I hereby appeal the denial, deferral or modification of the following service(s) or payment for service: _____
_____
_____
_____

I wish to appeal the denial, deferral, or modification of the above service(s) or payment for service(s) for the reasons indicated below: (for example, explain why you should receive the service and how it would benefit you or why we should pay for the service).

_____
_____
_____
_____
_____
_____

If I continue to receive the disputed service until the appeals process is completed, I fully understand that I may be financially responsible for payment of the disputed service if the decision to NOT cover or reduce services is upheld or not made in my favor.

I am requesting that **CalOptima Health PACE** continue to provide me with the disputed service
during the appeal process: (please check one) Yes☐ No☐

Please note: Additional pages may be attached if more space is needed.

Internal Staff Use Only:

Receipt and Acknowledgement of Appeal:

- ☐ Date Appeal for Reconsideration of Denial Letter received by the **QA Department**: _____
- ☐ Date **PACE Staff** Received Appeal for Reconsideration of Denial Letter documented into Appeal Log: _____
- ☐ Date **Medical Director** notified of the appeal concerning disputed health care services or urgent appeal: _____
- ☐ Date **Manager/Supervisor** notified of the appeal concerning coverage decisions or payment decisions**:** _____
  Date **QA Staff** sent a written acknowledgment of **standard** appeal to participant (within 5 days): _____

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30 calendar days (or more quickly if participant's health condition requires) from the day the appeal was received, either:

- ☐ The decision to *reverse* the denial, deferral, modification or refusal to pay for services is made.
  - The **Medical Director** or **QA staff** provides written response to **standard** appeal within 30 calendar days (or sooner if health condition requires). Notice of

Appeal Resolution, Attachment 5. Date Sent: _____ .

- ❑ The decision to **uphold** the denial, deferral, modification or refusal to pay for services is made.
    - The **Medical Director** or **QA staff** provides written response to standard appeal within 30 calendar days (or sooner if health condition requires) to participant and his/her representative, Health Plan Management System (HPMS), and Department of Health Care Services - Integrated Systems of Care Division DHCS-LTCD. Notice of Appeal Decision, Attachment 6. Date Sent: _____
    - The **Medical Director** or **QA staff** provides written information to participant and/or his/her representative on external review options for appeal. Date: _____

Expedited Review: If the appeal involves an imminent and serious threat to the health of the participant

- ❑ **QA Staff** informs participant by telephone or in person of receipt of **expedited** appeal (within 1 business day) of receipt of the expedited appeal): Date: _____ Time: _____
- ❑ The **Medical Director** or **QA staff** provides written response to reverse decision on expedited appeal within 72 hours of receipt of appeal. Notice of Appeal Resolution, Attachment 5. Date Sent: _____ OR
- ❑ The **Medical Director** or **QA staff** provides written response to uphold decision on expedited appeal within 72 calendar days to participant and his/her representative, HPMS, and DHCS-LTCD. Notice of Appeal Decision, Attachment 6. Date Sent: _____
    - The **Medical Director** or **QA staff** provides written information to participant and/or his/her representative on external review options for appeal.

Comments: _____