**You have the right to appeal**

You have a right to appeal any decision we make that denies your request for a health care service or treatment. You may request more explanation when your request for coverage of a health care service or treatment is denied or the health care service or treatment you received was not fully covered. Contact us when you:

* Do not understand why a request for coverage of a health care service or treatment was denied;
* Do not understand why the health care service or treatment was not fully covered;
* Want a copy (free of charge) of the guideline, criteria or clinical rationale that we used to make our decision; or
* Disagree with the denial and you want to appeal

**What is an adverse determination?**An “adverse determination” is a decision made by Acentra Health that the health care services furnished or proposed to be furnished to you should not be covered because they are not medically necessary or appropriate. Adverse determinations include, but are not limited to, decisions made by Acentra Health not to approve a prior authorization that your physician ordered for you.

**Who can request an appeal or reconsideration?**

You, your treating provider, or your designated representative, have the right to request a reconsideration (appeal) of this decision. You have the right to be represented by anyone you choose, including an attorney however, representation is not required. The appointment of a representative must be in writing and must be signed by the appropriate appealing party or an individual must be appointed to act as a representative by a court of competent jurisdiction.

**What is a reconsideration?**In cases involving medical necessity determinations, your provider is given an opportunity to submit additional information related to your case and to speak with our Medical Director or their designee. This is considered a reconsideration of our determination. A reconsideration is typically based on submission of additional information or a peer-to-peer discussion. This option is available only for initial pre-service or concurrent review determinations that are requested **within 14 days of the initial denial**. The peer-to-peer discussion shall be timely, preferably within one business day or at the convenience of the ordering provider **not to exceed 14 days from the date of the initial adverse determination.** A peer to peer is not required; you may file a reconsideration (appeal) without first requesting a peer to peer.

**When do I request a reconsideration (appeal)?**

Standard appeals must be requested in writing (mail or fax) and must be received by the health plan no later than 90 days from the date of the denial notification. Expedited appeal requests must be received by the health plan in writing by 12:00 noon of the next business day after you receive the denial notification if you are currently hospitalized and receiving the health care that has been denied, or within 3 business days of the date of the denial notification for outpatient services or inpatient services that have not yet been rendered.

**What information should be included in a request?**

Requests for reconsiderations or appeals must include the reason(s) for disagreeing with our determination as well as any new, pertinent information. The plan will thoroughly research your appeal. You may submit written comments, documents, records and other information relevant to your request. Our Medical Director or a physician consultant who was not involved in the original decision will review your record. We will also provide you with the medical reason for the decision. In cases where we do not change our original determination, we will give you information about your right to request further appeal. On request, and at no additional charge, you may obtain reasonable access to, and copies of all documents, records and information relevant to your appeal by sending a written request to Acentra Health. Upon receipt of all requisite information, we will contact you with the Plan’s decision within the following time frames:

* **Expedited Claims:** within 2 business days or 72 hours (whichever is sooner) from the time of your request for appeal, followed by a written confirmation within 24 hours of rendering a determination.
* **Pre-Service and Post Service Claims:** within 30 calendar days after receipt of appeal.

**Where do I send the request for an appeal or reconsideration?**

* Providers: Please submit your request at NMMIP.kepro.com
* Members: Please call Acentra Health medical management department at 844-547-4255