

Member Appeals Overview

Information in this policy does not apply to members with the Choice or Choice Plus products offered through Passport ConnectSM. For UnitedHealthcare's related policies/procedures, please go to www.uhcprovider.com/.

HMO, POS and PPO Members

Harvard Pilgrim Health Care (Harvard Pilgrim) provides its members, authorized representatives, and treating providers with a process to appeal decisions concerning coverage of healthcare services. Through this process, members, authorized representatives or treating providers can request a review of decisions concerning benefits and coverage. Benefit documents provide specific information on how to access this process.

Note: Member appeals may be related to availability of benefits or a claim or part of the utilization management process. Therefore, response is required within the timeframe requested (which may be from one to five business days, depending on the urgency of the appeal) to any requests for additional information that may arise in the course of reviewing an appeal.

Members are initially referred to the Member Services Department, where a Member Services Representative attempts to identify and resolve their concerns. If not satisfied, a member, a member's authorized representative, or provider on behalf of a member, may request an appeal verbally or in writing, and send it to the Appeals and Grievances Department.

Members, a member's authorized representative, or providers submitting an appeal on behalf of a member, may also file a verbal appeal with a Member Services Representative, who forwards the information regarding the appeal to the Appeals and Grievances Department. If an authorized representative is acting on behalf of the member, Harvard Pilgrim must receive written or verbal authorization from the member prior to initiation of the grievance. An Appeals and Grievances Analyst sends a letter acknowledging the receipt of the appeal to the member, and also requests any necessary medical documentation to ensure a thorough review. The Appeals and Grievances Analyst coordinates the investigation of the appeal and notifies the member and requesting provider in writing of the determination. In addition, prior to a decision being rendered, the Appeals and Grievances Analyst will provide the requester with a copy of any new or additional information received during the appeal process.

If a member of a fully-insured plan is not satisfied with the determination, their case could be eligible for external review by an external review agency contracted with the state. The review agency information is included in the determination letter. For certain self-insured employer groups, by an Independent Review Organization through a process coordinated by Harvard Pilgrim.

PUBLICATION HISTORY

01/01/23	reviewed; administrative edits
08/15/24	updated web address for United Healthcare and removed phone number