Grievances & appeals overview

The following information provides a brief overview of how to file a grievance, coverage decision and appeal. For a more detailed explanation of each process, please refer to your plan's Evidence of Coverage.

What is a complaint?

A complaint (also called a "grievance") is a formal process used for expressing dissatisfaction or problems related to the operations of the plan or quality of care or service received from the plan's medical providers.

What kinds of things are considered complaints?

If you have a problem or concern related to:

- Quality of care.
- Your right to privacy.
- Poor customer service.
- Long wait times for appointments, on the phone, at your doctor's office, etc.
- Information you get from us.
- How long we take to respond to a coverage decision or appeal.

What else should I know about complaints?

- Medicare guidelines give you 60 days to tell us after the problem occurs.
- You cannot be disenrolled from your plan for contacting us with a complaint.
- Your complaint will always be handled fairly and investigated following Medicare rules.

How do I file a complaint?

Calling Customer Service is the first step in addressing a concern. Please call the Customer Service number on the back of your Arkansas Blue Medicare member ID card. We will try to resolve the problem the first time we hear from you. If you'd rather write us, please mail or fax your complaint to:

Arkansas Blue Medicare
P.O. Box 3648
Little Rock, AR 72203
Fax: 1-501-301-1928

Note: You can also contact Medicare directly about a complaint by using their online complaint form: www/medicare.gov/MedicareComplaintForm/home.aspx

What is a coverage decision?

A coverage decision is the plan's decision on what is covered and how much we will pay.

How long does a coverage decision take?

- If your coverage decision is related to a medical service you haven't received yet, we will reply within 14 days.
- If your coverage decision is related to Part B or Part D prescription drugs you haven't received yet, we will reply within 72 hours.

What if I can't wait that long?

If waiting could cause serious harm to your health or hurt your ability to function, you can ask for a fast decision. We'll reply within 72 hours if it's related to a medical service that you haven't yet received, and 24 hours if it's related to a Part B or Part D prescription drug that you haven't yet received.

It's best to have your doctor or pharmacist request a fast coverage decision.

How do I ask for a coverage decision?

If your doctor does not request one for you, the best way to start is by calling the Customer Service number on the back of your Arkansas Blue Medicare member ID card. If you'd rather write us, please use the appropriate address or fax for your type of coverage decision:

Coverage decisions about medical care or service or Part B drugs

Write to:
Arkansas Blue Medicare
P.O. Box 3648
Little Rock, AR 72203
Medical care fax:
1-816-313-3014
Part B drugs fax:
1-816-313-3015

Coverage decisions about Part D prescription drugs

Write to:
CVS Caremark Part D Appeals and Exceptions
P.O. Box 52000, MC109
Phoenix, AZ 85072-2000
Fax: 1-855-633-7673
Access the request form:
caremark.com/portal/asset/Request_Medicare_Prescription_Drug_Coverage_Determination.pdf

What is an appeal?

An appeal is asking us to review, and change, our decision not to cover a service, item, or prescription.

How long do I have to appeal a decision?

Medicare guidelines give you 60 days to contact us about an appeal after you get our written notification.

How long will it take to hear from us about an appeal?

- If your appeal is related to a medical service you're waiting to receive, we will respond to you within 30 days.
- If your appeal is related to a Part B or Part D prescription drug, we will respond to you within 7 days.
- If your appeal is related to payment for a Part B or Part D drug you've already paid for, we will respond to you within 30 days.
- If your appeal is related to a medical service you've already received, or payment for a medical service you've already paid for, we will respond to you within 60 days.

What if I can't wait that long?

If you're appealing a decision about medical care or a prescription drug you haven't received yet, and waiting could cause serious harm to your health or hurt your ability to function, you can ask for a fast appeal. We will reply within 72 hours if it's related to a medical service, and 24 hours if it's related to a Part B or Part D prescription drug.

It's best to have your doctor or pharmacist request a fast appeal.

How do I appeal a decision?

It's often easiest to call the Customer Service number on the back of your Arkansas Blue Medicare member ID card. If you'd rather write us, please use the appropriate address or fax for your type of appeal:

Appeals about medical care or service or Part B drugs

Write to:
Arkansas Blue Medicare
Attn: Medicare Appeals
P.O. Box 2181
Little Rock, AR 72203
Fax: 1-501-378-3366

Appeals about Part D prescription drugs

Write to:
CVS Caremark Part D Appeals and Exceptions
P.O. Box 52000, MC109
Phoenix, AZ 85072-2000
Fax: 1-855-633-7673
Access the request form:
caremark.com/portal/asset/Request_Medicare_Prescription_Drug_Coverage_Determination.pdf

What if I would like someone else to start a grievance, coverage decision, or appeal?

If someone is acting on your behalf (a representative) to ask for a grievance, coverage decision, or appeal, make sure you fill out and send us an Appointment of Representative form. We won't be able to start the process without it.

Note: Your doctor doesn't need to complete the Appointment of Representative form if they are asking for a coverage decision or appeal.

How do I check the status of a complaint, coverage decision, or appeal I filed or that was filed on my behalf?

For process or status questions related to your grievance, coverage decision, and/or appeal, please call the Customer Service number on the back of your member ID card.

How does the plan perform in relation to grievances and appeals?

You may also call the Customer Service number on the back of your member ID card for the number of grievances, appeals and exceptions filed with Arkansas Blue Medicare plans.

What are the Customer Service number and hours?

If you do not have immediate access to your member ID card, please call Customer Service at **1-844-463-1088** (TTY: **711**). From April 1 through September 30, hours are 8 a.m. to 8 p.m. Central, Monday through Friday. From October 1 through March 31, hours are 8 a.m. to 8 p.m. Central, seven days a week.