Appeals and Grievances

Appeal: A type of complaint a member (or an authorized representative) makes when the member disagrees with an action taken or wants Amerigroup to reconsider a decision.

Complaint: Any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, the claims regarding the right of the enrollee to receive services or receive payment for services previously rendered. It also includes a plan's refusal to provide services to which the enrollee believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee or their representative may make the complaint or dispute, either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame.

Current members should contact Member Services for process or status questions or to file a verbal grievance.

How to Submit an Appeal or Grievance or Complaint

- By telephone: Call Member Services toll free at 1-866-805-4589 (TTY 711).
- Via Fax: 1-888-458-1406
- In writing:

Medicare Complaints Appeals and Grievances
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, OH 45040

An **Appointment of Representative (AOR) Form** is required if someone other than the member is filing a complaint or appeal on behalf of the member. There are some exceptions: Medical Doctors are not required to fill out an AOR when initiating an appeal for a Part C (Medical Appeal). However, The Centers for Medicare & Medicaid Services (CMS) require an AOR from Medical Doctors for Part D (Pharmacy) appeals, **except** for expedited Part D appeals. Personal Representative Forms will **not** be accepted in lieu of an AOR. The appeal timeframe will start once the AOR is signed by the member and representative and returned to the Medicare Complaints Appeals and Grievances (MCAG) department.

Members can get an AOR form by calling Member Services at 1-866-805-4589 (TTY 711) or by downloading it from the Centers for Medicare & Medicaid Services (CMS) website.