- Ask the primary care provider (PCP) for the form
- Call our Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711) for the form

Take or mail the completed form to the PCP or specialist who will then know what kind of care the member would want to have. The member can change his or her mind at any time. If the member does, call the PCP to remove the form from his or her medical record. Fill out and sign a new form if he or she wishes to make changes.

Remember to:

- Give a copy of the completed form to the health care agency, guardian and the physician
- Keep a copy at home in a place where it can be easily found if needed
- Look at the form regularly to make sure it says what the member wants

You can get a copy of the Georgia Advance Directive for Health Care Act online at **https://aging.georgia.gov/documents/georgia-advance-directive-health-care.**

You can ask for a copy of this form and its instructions at no cost by writing to the Georgia DHS Division of Aging Services at:

Georgia DHS Division of Aging Services
2 Peachtree St. NW
Suite 33-263
Atlanta, GA 30303

If you have questions or need more information, call the Division's Information and Referral Specialist at 404-657-5258. If you signed an advance directive and believe that a doctor or hospital has not followed the instructions in it, you can file a complaint. You can call the Department of Community Health at 1-800-878-6442.

You can also write to:

Regulation Division
Complaints and Investigations Healthcare Facility
Department of Community Health
2 Peachtree St. NW
Atlanta, GA 30303

COMPLAINTS, GRIEVANCES AND APPEALS

Complaints and Grievances

A complaint or grievance is an oral or written expression of dissatisfaction about services or care the member received. Possible subjects for grievances include:

- Quality of care or services provided
- Rudeness of a provider or employee
- Failure to respect your rights

All levels of grievances must be completed within 90 calendar days. Please call the Georgia Families 360°$_{SM}$ Member Intake Line if you have questions or concerns about services or network providers.

Level 1 Grievance
We will try to solve your complaint on the phone. If we cannot take care of the problem during your call, you can file a Level 1 grievance. A Georgia Families 360°$_{SM}$ Member Intake Line representative can provide:

- Help writing and filing a grievance letter
- Verbal translation of other languages
- Help for those who are blind or have low vision
- TDD/TTY lines for the deaf or hard of hearing through 711

The member's legal guardian or your authorized representative can file a grievance. The member's doctor cannot file a grievance for the member unless the doctor has been named as the member's personal representative. The member or responsible party must send written approval to have a representative file a grievance on his or her behalf.

To file a grievance, you or your representative can call, fax or send us a letter. You may call the Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711) for help with writing a letter.

Send your letter to:

Appealsand Grievances Department
Amerigroup Community Care
4170 Ashford Dunwoody Road, Suite 100
Atlanta, GA 30319
Fax: 1-877-842-7183

We will send you a letter within 10 working days to let you know we got your grievance. If you need a verbal translation, please call the Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711) toll free.

We will look into the member's grievance when we get it. We will send you a letter within 30 calendar days of when you told us about your grievance or sooner if your health condition calls for it. This letter will tell you the decision Amerigroup makes and the reasons for our decision. We will include information on how to file a Level 2 grievance.

Level 2 Grievance
If you're not happy with the answer to your Level 1 grievance, you can ask for a grievance committee hearing. You must write or call us with this request within 10 working days from the date of the letter with the first grievance answer. Send your letter to:

Appeals and Grievances Department
Amerigroup Community Care
4170 Ashford Dunwoody Road, Suite 100
Atlanta, GA 30319
Toll free: 1-855-661-2021 (TTY 711)

The Grievance Committee is made up of Amerigroup staff and health care providers who were not involved in the first decision. A person who was involved in the first decision may present information to the committee or answer questions. Amerigroup will send the member a letter within 10 working days to let the member know we received the grievance. If the member needs a verbal translation, please call the Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711) toll free.

We will try to find a day and time for the meeting so the member can be there. We will tell the member the date, time and place of the meeting at least seven calendar days ahead of time. The member can bring someone to the meeting if the member wants to. The member does not have to come to the meeting.

We will send the member a letter within 30 calendar days — or sooner if the member's health condition calls for it — of the meeting request to tell the member what the committee decides about the member's grievance and the reasons for the decision. The total time for Amerigroup to complete the total grievance process with written notification will be completed within 90 calendar days from the filing date. This is our final decision.

If the member or an authorized representative files or makes a complaint or grievance, we will not hold it against the member. We will still be here to help the member get quality health care.

Appeal process

An appeal is an appeal the member makes when he or she doesn't agree with a decision we made about his or her care. There may be times when we say we will not pay for care that has been recommended by the member's doctor. The member or the member's parent, legal guardian, or authorized representative can ask for an appeal if we:

- Deny or limit a service the member or the member's doctor asked us to approve
- Reduce, suspend or stop services the member has been getting that we already approved
- Do not pay for the health care services the member gets
- Fail to give services in the required time frame
- Fail to give the member a decision on an appeal he or she already filed in the required time frame
- Do not let you exercise your right to get services from providers who do not work with our health plan. This is when you live in an area with only one health plan
- Deny your request to dispute a financial charge. This includes your percentage of the costs, copayments, monthly payments, deductibles, and other member financial charges

The member will get a letter from us when any of these actions happen. This letter is called an adverse benefit determination. The adverse benefit determination will tell the member how and why we made

our decision. The member can file an appeal if they don't agree with our decision.

The member must file an appeal within 30 calendar days from the date on his or her adverse benefit determination letter. There are three ways to file an appeal:
1. The member may call the Member Intake Line at 1-855-661-2021 (TTY 711). We'll send the member an Appeal Form. Fill out the entire form, and mail it back to us at the address below. The member must follow up with a written, signed request. Have the member's doctor send us his or her medical information about this service.
2. The member can fax a letter to Quality Management at 1-877-842-7183.
3. The member can send us a letter to the address below. The member may call the Member Intake Line at 1-855-661-2021 (TTY 711) for help with writing a letter. Include information such as the care the member is looking for and the people involved. Have the member's doctor send us his or her medical information about this service. The address is:

Appeals
Amerigroup Community Care
P.O. Box 62429
Virginia Beach, VA 23466-2429

We'll send the member a letter within 10 working days of getting the member's appeal request. It will let the member know we got the appeal.

If the member doesn't send us the appeal request within 30 days of the date on the adverse benefit determination letter, the member's request will be denied. We'll send the member a letter if this happens.

We'll answer the member's appeal request based on the type of appeal the member files. For life-threatening or urgent services also known as expedited appeals, we'll answer within 72 hours of the appeal request. For nonemergency services also known as standard appeals, we'll answer within 45 calendar days of the appeal request.

A doctor who hasn't seen the member's case before will look at the member's appeal request. This doctor will:
- Make the decision on the member's appeal
- Report to a doctor who has not looked at the member's case in the past

At any time during the appeal process, the member or the member's representative may:
- Have the right to access copies of all documents related to the member's appeal
- Have the right to copies of all documents related to the member's appeal free of charge
- Provide additional information or facts to Amerigroup in person or in writing
- Get a copy, free of charge, of the benefit guide, guidelines, criteria or protocol we used to decide the member appeal

If the member needs to give us more information, the member can ask us for up to 14 more calendar days. If needed, we may also ask for 14 more calendar days to make a decision on a standard appeal. If

we need more time, we'll send the member a letter telling him or her why. We'll do this if we feel more information is needed, and it's in the member's best interest.

If the member needs a verbal translation, please call the Member Intake Line at 1-855-661-2021 (TTY 711)) toll free. One of our representatives can:

- Help write a request for an appeal
- Help file an appeal
- Set up verbal translation into other languages
- Arrange help for those who are blind or have low vision

A toll-free TTY line for people who are deaf or hard of hearing is available by calling 711.

Expedited Appeals

An expedited appeal is an appeal that gets the member a decision fast. There may be times when the member or the member's provider will want us to make a faster appeal decision. This could be because the member or the member's doctor feel taking the time for the standard appeal process could seriously harm the member's life or health.

We will answer the member's expedited appeal request within 72 hours after we get the member's request. If the member's health condition calls for it, it will be sooner. The member, the member's authorized representative, or the member's doctor can ask for an expedited appeal in two ways:

1. The member can call the Member Intake Line at 1-855-661-2021 (TTY 711) (a written request is not needed)
2. The member can fax a letter to Quality Management at 1-877-842-7183

The member has the right to submit written comments, documents or other information, like medical records or provider letters that might help the member's appeal. The member must do so within 72 hours of the request for expedited appeal.

If the member asks for an expedited appeal and we don't agree the member's request for an appeal should be expedited, we'll call the member right away. We'll send the member a letter within two calendar days to let the member know how the decision was made. We'll also let the member know the appeal request will be reviewed through the standard review process. See the **Appeals** section for help. The member may file a grievance if the member doesn't agree with this decision by calling the Member Intake Line at 1-855-661-2021 (TTY 711).

ADMINISTRATIVE LAW HEARING

Medicaid eligible members

If the member doesn't agree with our appeal decision, the member can ask for a hearing with an administrative law judge. The member can ask for a hearing only after the member has gotten the appeal resolution letter. The member must ask for a hearing within 30 days from the date on the appeal resolution letter. The member's provider cannot ask for a hearing for the member unless the member names him or her as his or her personal representative.

To ask for a hearing send a letter to:

Amerigroup Community Care
Quality Management Department
Administrative Law Hearings
4170 Ashford Dunwoody Road, Suite 100
Atlanta, GA 30319

At any time during the Administrative Law Hearing process, the member or the member's representative may:

- Obtain and examine a copy of the documents that will be used for review
- Provide additional information or facts to Amerigroup in person or in writing

The member can ask for a continuation of benefits during the Administrative Law Hearing process. See the section **Continuation of Benefits** for help.

The decision reached by an Administrative Law Hearing will be final.

The member can request an administrative law hearing by sending a letter to:
Amerigroup Community Care
Quality Management Department
Administrative Law Hearings
4170 Ashford Dunwoody Road, Suite 100
Atlanta, GA 30319

The member may also submit the complaint to the Department of Insurance. The address is:

Department of Insurance
2 Martin Luther King, Jr. Drive
West Tower, Suite 704
Atlanta, GA 30334

The Department of Insurance telephone and fax information is:
Local phone: 404-656-2070
Toll free: 1-800-656-2298
Fax: 404-657-8542

The Office of State Administrative Hearings will tell the member of the time, place and date of the hearing. An administrative law judge will hold the hearing. The member may speak for his or herself or let a friend or family member speak for him or her. The member may get help from a lawyer. The member may also be able to get free legal help. If the member wants a lawyer, please call one of these telephone numbers:

- Georgia Legal Services: 404-206-5175
- Georgia Advocacy Office: 1-800-537-2329
- Atlanta Legal Aid:
  - 404-377-0701 (DeKalb-Gwinnett Counties)
  - 770-528-2565 (Cobb County)
  - 404-524-5811 (Fulton County)
  - 404-669-0233 (South Fulton-Clayton Counties)
  - 678-376-4545 (Gwinnett County)
  - State Ombudsman Office: 1-888-454-5826

You may also ask for free mediation services after you have filed a request for hearing. Please call 404-657-2800.

We will comply with the administrative law hearing decision.

CONTINUATION OF BENEFITS

You may ask Amerigroup to continue to cover the member's benefits during the appeal and administrative law hearing process. If coverage of a service they are receiving is denied or reduced and you want to continue that service during the appeal or administrative law hearing committee review, you can call the Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711) to request it.

You must call to ask us to continue the member's benefits within 10 calendar days of when we mailed you the notice that said we wouldn't cover or pay for a service.

We must continue coverage of the benefits until:

- You withdraw the appeal or administrative law hearing request
- Ten calendar days from the date of the appeal resolution letter have passed, and you have not made a request to continue benefits until an administrative law hearing decision is reached
- An appeal or administrative law hearing decision is reached and is not in the member's favor
- Authorization expires or the member's service limits are met

The member may have to pay for the cost of any continued benefit if the final decision is not in their favor. If a decision is made in the member's favor as a result of your appeal or appeal, Amerigroup will authorize and pay for the services we said we would not cover before.

MAINTAINING MEDICAID BENEFITS BEYOND AGE 18

Medicaid provides two options for youth who age out of foster care or who opt out of foster care.