- Call Member Services at 1-800-600-4441 (TTY 711) for the form

Take or mail the completed form to your PCP or specialist who will then know what kind of care you want to have. You can change your mind at any time. If you do, call your PCP to remove the form from your medical record. Fill out and sign a new form if you wish to make changes.

Remember to:
- Give a copy of the completed form to your health care agency, your family and your 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 you want

You can get a copy of the Georgia Advance Directive for Health Care Act by going online to **http://aging.dhs.georgia.gov**.

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 you 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 Member Services if you have questions or concerns about services or network providers.

Amerigroup will try to solve your complaint on the phone. If we cannot take care of the problem during your call, you can file a grievance.

A Member Services representative can provide:

- Help writing and filing a grievance letter
- Other language translations
- Help for those who are blind or have low vision
- TDD/TTY lines for the deaf or hard of hearing toll free at 711

You, your parent, your legal guardian or your authorized representative (a person you prefer to help you) can file a grievance. Your doctor cannot file a grievance for you.

To file a grievance, you or your representative can call, fax or send us a letter. You may call Member Services at 1-800-600-4441 (TTY 711) for help with writing a letter. Adoption assistance members in the Georgia Families 360°$_{SM}$ program can call the Georgia Families 360°$_{SM}$ Member Intake Line at 1-855-661-2021 (TTY 711).

Send your letter to:

Appeal and Grievance 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 Member Services at 1-800-600-4441 (TTY 711) toll free.

We will look into your grievance when we get it. We will send you a letter within 90 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.

Appeal process

An appeal is a request you make when you don't agree with a decision we made about your care. There may be times when we say we will not pay for care that has been recommended by your doctor. You or your parent, legal guardian, or authorized representative can ask for an appeal if we:

• Deny or limit a service you or your doctor asks us to approve
• Reduce, suspend or stop services you've been getting that we already approved
• Do not pay for the health care services you get
• Fail to give services in the required time frame
• Fail to give you a decision on an appeal you 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, copays, monthly payments, deductibles and other member financial charges.

You 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 you how and why we made our decision. You can file an appeal if you don't agree with our decision.

You must file an appeal within 60 calendar days from the date on your adverse benefit determination letter. There are three ways to file an administrative review:
1. You may call Member Services at 1-800-600-4441 (TTY 711). We'll send you an Appeal Form. Fill out the entire form, and mail it back to us at the address below. You must follow up with a written, signed request. Have your doctor send us your medical information about this service.
2. You can fax a letter to Quality Management at 1-877-842-7183.
3. You can send us a letter to the address below. You may call Member Services at 1-800-600-4441 (TTY 711) for help with writing a letter. Include information such as the care you are looking for and the people involved. Have your doctor send us your medical information about this service. The address is:

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

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

If you don't send us your appeal request within 60 days of the date on the Adverse Benefit Determination letter, your request will be denied. We'll send you a letter if this happens.

We'll answer your appeal request based on the type of appeal you file. 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 30 calendar days of the appeal request.

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

At any time during the appeal process, you or your representative may:
- Have the right to access copies of all documents related to your appeal
- Have the right to copies of all documents related to your 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 your appeal

If you need to give us more information, you 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 you a letter telling you why. We'll do this if we feel more information is needed, and it's in your best interest.

If you need a verbal translation, please call Member Services at 1-800-600-4441 (TTY 711) toll free. A Member Services representative can give:

- Help writing a request for an appeal
- Help with filing an appeal
- Verbal translation of other languages
- 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 you a decision fast. There may be times when you or your provider will want us to make a faster appeal decision. This could be because you or your doctor feels taking the time for the standard appeal process could seriously harm your life or health.

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

1. You can call Member Services toll free at 1-800-600-4441 (TTY 711) (a written request is not needed)
2. You can fax a letter to Quality Management at 1-877-842-7183

You have the right to submit written comments, documents or other information, like medical records or provider letters that might help your appeal. You must do so within 72 hours of your request for expedited appeal.

If you ask for an expedited appeal and we don't agree your request for an appeal should be expedited, we'll call you right away. We'll send you a letter within two calendar days to let you know how the decision was made. We'll also let you know your appeal request will be reviewed through the standard review process. See the **Appeals** section for help. You may file a grievance if you don't agree with this decision by calling Member Services at 1-800-600-4441 (TTY 711).

STATE FAIR HEARING

Medicaid eligible members

If you don't agree with our appeal decision, you can ask for a State Fair Hearing with an administrative law judge. You can ask for a hearing only after you have gotten your Appeal Resolution letter. You must ask for a hearing within 120 days from the date on the appeal resolution letter. Your provider cannot ask for a hearing for you unless you name him or her as your personal representative.

To ask for a hearing send a letter to:
Amerigroup Community Care
Quality Management Department
State Fair Hearing
4170 Ashford Dunwoody Road, Suite 100
Atlanta, GA 30319

At any time during the State Fair Hearing process, you or your 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

You can ask for a continuation of benefits during the State Fair Hearing process. See the section **Continuation of Benefits** for help.

The decision reached by a State Fair Hearing will be final.

You may also submit your complaint to the Department of Insurance. Their address is listed below.

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 you of the time, place and date of the hearing. An administrative law judge will hold the hearing. You may speak for yourself or let a friend or family member speak for you. You may get help from a lawyer. You may also be able to get free legal help. If you want a lawyer, please call one of these telephone numbers:

- 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)
- Georgia Legal Services program: 404-206-5175
- Georgia Advocacy Office: 1-800-537-2329
- 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 State Fair Hearing decision.

Formal Grievance Committee (PeachCare for Kids® members)
If you don't agree with our appeal decision, you can ask for a Formal Grievance Committee Review from the Department of Community Health (DCH). You can ask for a review only after you have gotten your appeal resolution letter. You must ask for a review within 120days from the date on the appeal resolution letter. Your provider cannot ask for a review for you unless you name him or her as your personal representative.

To ask for a Formal Grievance Committee review, send a letter to:
Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree St., 37th Floor
Atlanta, GA 30303-3159

You can ask for a continuation of benefits during the formal grievance committee process. See the section **Continuation of Benefits** for help.

The outcome reached by the DCH Formal Grievance Committee review will be final.

We will comply with the DCH Formal Grievance Committee Review decision.

OFFICE OF THE OMBUDSMAN LIAISON

What is the Office of the Ombudsman?
The Amerigroup Managed Care Office of the Ombudsman helps solve problems from a neutral view to ensure our members get all medically necessary covered services. The Ombudsman provides a voice to speak and acts on behalf of Amerigroup members. They make sure your voice is heard.

The Ombudsman Liaison reviews and resolves complaints made by or on behalf of Amerigroup members. Any concerned member may call to express their concerns and complaints through the Amerigroup Ombudsman.

What does the Amerigroup Office of the Ombudsman do?
- Listens to your concerns
- Serves as an objective resource to resolve health care issues
- Gathers additional information related to your concern
- Helps members with urgent enrollment and disenrollment problems
- Offers information and referrals
- Identifies ways to improve the effectiveness of health care services
- Educates members on how to effectively use the health care system
- Helps make a plan to address concerns and makes suggestions

The Amerigroup Ombudsman can be reached at:

- Phone – 1-855-558-1436
- Email – helpOMB@amerigroup.com
- Fax – 1-888-375-5067