

Take or mail the completed form to your provider 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 provider 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 provider
- 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 your family planning or primary care provider 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. 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 grievance. Possible subjects for grievances include:

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

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. Send your letter to:

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

We'll send you a letter within 10 business days to let you know we got your grievance. If you need verbal translation of the letter is needed, please call Member Services toll free at 1-800-600-4441 (TTY 711).

We'll look into your grievance when we get it. We'll send you a letter within 90 calendar days or sooner, if your health condition calls for it, with a response to your grievance. This letter will tell you the decision Amerigroup made and the reasons for our decision.

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 provider cannot file a grievance for you as your provider. You must send written approval to have a representative file a grievance for you.

Complaints or grievances do not relate to decisions to deny or limit services. Please call Member Services if you have questions or concerns about services or providers who work with our plan.

## **APPEALS**

P4HB services are limited to those noted in the sections above. Amerigroup cannot pay for services that aren't related to the P4HB program. Sometimes, providers ask for services that aren't related to the P4HB program. If this happens, a letter will be mailed to you and your provider for services that aren't approved. This letter is called an adverse benefit determination.

An adverse benefit determination is when we:

- Deny or limit a service you or your provider asked us to approve
- Lessen, suspend or stop services you've been getting that we already approved
- Don't 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

The adverse benefit determination letter will explain how you, your legal representative or your provider (with your written consent) or a legal representative of a deceased enrollee's estate can ask for an appeal of the decision. An appeal is when you ask us to look again at the care your provider asked for and we said we would not pay for.

You, your authorized representative (a person you prefer to help you), your IPC PCP or the family planning provider taking care of you at the time with your written consent, or a legal representative for a deceased enrollee's estate may request an appeal. If you use a representative (including your provider), you must write a letter or complete the authorized representative form that was provided to you, telling us this person is allowed to represent you.

You may file an appeal within 60 calendar days of the date of the first letter from us that says we will not pay for the service. You can ask for a continuation of benefits during the appeal process. See the **Continuation of Benefits** section for help.

You may ask for an appeal by calling Member Services toll free at 1-800-600-4441 (TTY 711). You must also send in a written request. One of our Member Services representatives can help you with your written request.

An oral request begins the time frame for the appeal process, but a written request is required and must be received within 30 calendar days from the date of the first letter from us that says we will not pay for the service. If we don't receive a written request within 60 calendar days from the date of the first letter from us that says we will not pay for the service, your request will be closed.

You may ask for an appeal of our decision in two ways:

1. You may call Member Services at 1-800-600-4441 (TTY 711) and we will send you an Appeal Form. Fill out the entire form, and mail it back to us at the address below. Have your provider send us your medical information about this service.
2. 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 provider send us your medical information about this service. The address is:

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

When we get your request, we will send you a letter within 10 working days. This letter will let you know we got your appeal request.

We will start working on your request when you first tell us you want an appeal. A provider who has not seen your case before will look at your appeal. He or she will decide how we should handle your appeal. We will send you and your provider a letter with the answer to your appeal. The letter will tell you the reasons for our decision.

We will do this within 30 calendar days from when we get your appeal request. We have a process to answer your appeal quickly if the care your provider says you need is urgent. Please see the section **Expedited Appeals** for help.

If there is a delay we cannot control or more information is needed, we will send you a letter. The letter will tell you we may need to extend the time frame up to 14 calendar days to look at your appeal and why. If you or your authorized representative acting on your behalf with your written consent requests an extension, the review may be extended up to 14 calendar days.

If we aren't able to meet the required time frames noted above, you will receive a notice for failure to act.

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 a verbal translation, please call Member Services at 1-800-600-4441 (TTY 711) toll free.

A Member Services representative can provide:

- 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.

If you, your authorized representative (a person you give permission to help you), your IPC PCP or the family planning provider taking care of you at the time, with your written consent, or a legal representative of a deceased enrollee's estate files an appeal, we will not hold it against you, your authorized representative or your provider. We will be here to help you get quality health care.

### **Expedited appeals**

You, your authorized representative (a person you give permission to help you), your IPC PCP or your family planning provider taking care of you at the time (with your written consent), the person you ask to file an appeal for you (with written consent), or a legal representative of a deceased enrollee's estate can request an expedited appeal.

You can ask for an expedited appeal if you or your provider feel that taking the time for the standard appeal process could seriously harm your life or your health.

You can ask for an expedited appeal in two ways:

- Call Member Services toll free at 1-800-600-4441 (TTY 711)
- Fax Quality Management at 1-877-842-7183

When we get your letter or phone call, we will send you a letter with the answer to your appeal request. The letter will tell you the reasons for our decision. We will do this within 72 hours after we get your appeal request or sooner if your health condition calls for it. You have the right to submit written comments, documents or other information, such as medical records or provider letters that might help your appeal. You must do so within 72 hours of your request for an expedited appeal.

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

If the decision of your expedited appeal agrees with our first decision, an Amerigroup representative will call you. We will also send you a letter within two calendar days to let you know our decision and that we will not pay for the service asked for.

If there is a delay we cannot control or more information is needed, we will send you a letter. The letter will tell you we need to extend the time frame up to 14 calendar days to look at your expedited appeal. If you or your authorized representative or provider acting on your behalf with your written consent requests an extension, the review may be extended up to 14 calendar days.

## STATE FAIR HEARING

You, your authorized representative or a legal representative of a deceased enrollee's estate may ask for a state fair hearing. You must send a letter after you have gone through the Amerigroup appeal process. You must ask for a state fair hearing within 120 calendar days from the date of the Appeal Resolution letter.

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 P4HB benefits during the state fair hearing process. See the section **Continuation of P4HB Benefits** for help. The decision reached by a state fair hearing will be final.

You can ask for a state fair hearing by sending a letter to:

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

You may also ask for a state fair hearing from the Department of Insurance. Their 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 Fair Hearings will tell you 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:

- Georgia Legal Services: 1-800-498-4469
- 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 a hearing. Please call 404-657-2800.

We will comply with the state fair hearing decision.

## **CONTINUATION OF P4HB BENEFITS**

You may ask Amerigroup to continue to cover your P4HB benefits during the appeal and state fair hearing processes. If coverage of a service you are receiving is denied or reduced and you want to

continue that service during your appeal or state fair hearing, you can call Member Services at 1-800-600-4441 (TTY 711) to request it.

You must call to ask us to continue your P4HB 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 your P4HB benefits until:

- You withdraw the appeal, state fair hearing or formal grievance committee request
- Ten calendar days from the date of the appeal decision letter have passed, and you have not made a request to continue P4HB benefits until a state fair hearing decision is reached
- A state fair hearing decision is reached and is not in your favor
- Authorization expires or your service limits are met

You may have to pay for the cost of any continued P4HB benefit if the final decision is not in your favor. If a decision is made in your favor as a result of your appeal, Amerigroup will authorize and pay for the services we said we would not cover before.

### **Payment reviews**

If you receive a service from a provider and we don't pay for that service, we may send you a notice called an Explanation of Benefits (EOB). This is not a bill. The EOB will tell you:

- The date you got the service
- The type of service it was
- The reason we cannot pay for the service

The provider, health care place or person who gave you this service will get a notice called an Explanation of Payment. If you get an EOB, you do not need to call or do anything at that time.

You may call if you want to or if your provider disagrees with the decision. You can ask Amerigroup to look again at the service we said we would not pay for. You must ask for us to do this within 30 calendar days of getting the EOB. To do this, you or your provider can call Member Services toll free at 1-800-600-4441 (TTY 711). You can also mail your request and medical information for the service to:

Amerigroup Community Care  
Quality Management Department  
Appeals and Grievances  
4170 Ashford Dunwoody Road, Suite 100  
Atlanta, GA 30319

We can accept your request by phone, but you must follow up in writing. You have the right to ask for a grievance. See the section **Complaints, Grievances and Appeals** for help.

Appeals for services outside of the P4HB program are not handled by the Amerigroup P4HB program.

You or your family planning or primary care provider (with your written consent to act as your representative) can ask for an appeal if we say we won't pay for the care. We will acknowledge your request for an appeal within 10 calendar days. We'll let you and your provider know the final decision within 30 calendar days after we get the appeal request. The appeal request can be for:

- Services that are not approved
- Services that have been changed to less than requested

## **OTHER INFORMATION**

### **If you move or your family size changes**

You should call your Division of Family and Children Services caseworker as soon as you move or your family size changes to report the change. Once you call your caseworker, you should call Member Services. You can also go to the Georgia Gateway website at [www.gateway.ga.gov](http://www.gateway.ga.gov) to report a move or change in family size. You will continue to get health care services through us in your current area until the address is changed. You must call Amerigroup before you can get any P4HB services in your new area unless it is an emergency.

### **Renew on time**

We want you to keep getting your P4HB benefits from us if you still qualify. Your health is very important to us. Keep the right care. Don't lose your P4HB benefits.

You must renew your P4HB eligibility every 12 months. You'll get a renewal note in the mail before the deadline. It's important to follow the instructions in this letter. If you need help, call the P4HB line at 1-877-744-2101 for help or Member Services. If you don't renew by the date in the letter, you may lose your health care benefits. For help or to find out the date you need to renew your benefits, call the P4HB line at 1-877-744-2101.

### **Reasons why you can be disenrolled from Amerigroup**

There are several reasons you could be disenrolled from Amerigroup without asking to be disenrolled. These are listed below. If you have done something that may lead to disenrollment, we will contact you. We will ask you to tell us what happened.

You may be disenrolled from Amerigroup immediately if:

- You are no longer eligible for the P4HB program
- You have reached the end of the 24-month eligibility for IPC services (you may be eligible for Family Planning services)
- You become pregnant while enrolled
- You become infertile (sterile) through a medical procedure
- You are sent to jail or prison
- You use these services through fraud or abuse, such as letting someone else use your Amerigroup P4HB ID card
- You are disenrolled by the Georgia Department of Community Health