5.4 Claims Appeals/Review and Reconciliation Process

Providers who are dissatisfied with the outcome of the Review and Reconsideration may submit a **written** request for a formal appeal within **sixty** (60) calendar days from the date listed on the reconsideration determination letter.

Providers should submit all written requests for an appeal of a claim determination to the following location:

Provider Claim Appeals
PO Box 958432
Lake Mary, FL 32795-8432

Providers should provide a written statement explaining why they disagree with Senior Health Partners decision regarding the review and reconsideration, and submit a copy of that determination. Providers should also specify the name, address and telephone number of the individual who may be contacted regarding the appeal, and include any additional relevant documentation to support the providers position. Senior Health Partners will not accept appeals from providers that are not made in writing and fail to address the reason for the appeal.

For appeals on payments rates, providers should specify in writing the basis for the dispute and enclose all relevant documentation including, but not limited to, contract rate sheets or fee schedules.

Senior Health Partners will send a letter to the provider acknowledging the request for an appeal with the fifteen (15) business days of receipt. This acknowledgment letter will request any additional information that may be necessary in order for Senior Health Partners to render a decision. If additional information is requested, the provider must submit the information with (30) calendar days. If a provider fails to submit the additional requested information, the file will be closed and the denial letter will be issued to the provider.

Upon the receipt of all the necessary information, Senior Health Partners will issue a decision, in writing, within thirty (30) calendar days of receipt of the additional requested information. If medical records are necessary to resolve a claim determination, excluding those claims which are denied for failure to obtain prior authorization, the supporting clinical documentation will be retrospectively reviewed by staff in the Quality Management Department and or Senior Health Partners' Medical Director.

Senior Health Partners will not consider appeals that are not filed according to the procedures set forth above. If a provider files an appeal after the (60) calendar day time frame, the request is deemed ineligible and will be dismissed. Providers will not be paid for any services irrespective of the merits of the underlying dispute if an appeal is not filed within timely filing requirements.

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