Disputed Claims Process

How to file internal and external appeals

Please follow the instructions in this document if you disagree with:

- a decision regarding services that require prior approval or pre-service as described in the CareFirst BlueChoice, Inc., Plan brochure; or
- a contractual benefit determination made on a post-service claim for a service, supply or treatment you already received.

These instructions may also be found in Sections 3, 7 and 8 of the CareFirst BlueChoice, Inc., Plan brochure.

You may designate an authorized representative (including an attorney) to act on your behalf to appeal claims decisions to us. For urgent care claims, a healthcare professional with knowledge of your medical condition will be permitted to act as your authorized representative without your express consent.

For all other cases, parties acting as your representative—such as medical providers or family members—must provide a copy of your written consent with the review request.

Internal appeals

Non-urgent pre-service and post-service claims

1. To initiate an appeal, you must ask us in writing to reconsider our initial decision. You must also:
   a. Write to us within six months from the date of our decision; and
   b. Send your request either by mailing it to: Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114; or by submitting an electronic copy via the CareFirst member portal, MyAccount; and
   c. Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in the brochure; and
   d. Include copies of documents that support your claim such as physicians' letters, operative reports, bills, medical records, and EOB forms; and
   e. Include your email address (optional for member) if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly.

We will provide you any new or additional evidence considered, relied upon, or generated in connection with your claim and any new rationale for our claim decision. You will receive this information well before a decision on your appeal is reached, so you have adequate time to respond.

However, our failure to provide you with new evidence or rationale in a timely manner shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the Office of Personnel Management (OPM) review stage.

2. In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:
   a. Pre-certify your hospital stay or, if applicable, approve your request for prior approval for the service, drug or supply; or
   b. Maintain our denial; or
   c. Ask you or your provider for more information.
3. In the case of a post-service claim, we have 30 days from the date we receive your request to:
   a. Pay the claim; or
   b. Maintain our denial; or
   c. Ask you or your provider for more information.

For both non-urgent pre-service and post-service claims, you or your provider must send the information so that we receive it within 60 days of our request. We will then make our decision with the new information or, if the information was not received, with the information we already have within 30 additional calendar days. We will write to you with our decision.

Urgent care claims

If you have an urgent care claim (i.e., when waiting for your medical care or treatment could seriously jeopardize your life, health or ability to regain maximum function; or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment), we will expedite our review and notify you of our decision within 72 hours. To request an expedited appeal, call the health plan customer service number on the back of your ID card.

If you ask us to review your claim as urgent care, we will check your documents and decide if it qualifies based on a typical person's understanding of health and medicine.

We will expedite the review process, which allow oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods. If you do not provide sufficient information for us to decide on your expedited request within 24 hours, we will contact you. You will have up to 48 hours to provide the necessary information.

If your case warrants expedited handling, we will make our decision on the claim within 48 hours of either (a) the time we received the additional information or (b) the end of the 72-hour time frame, whichever is earlier.

External appeals

Non-urgent pre-service and post-service claims

If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us. If we did not answer that request within 30 days; or
- 120 days after we asked for additional information. If we did not send you a decision within 30 days after we received the additional information.

You may send an appeal to OPM at:

United States Office of Personnel Management
Healthcare and Insurance

Federal Employee Insurance Operations
FEHB 2
1900 E Street, N.W.
Washington, D.C. 20415-3620

Please provide OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call; and/or
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Urgent care claims

You may request that your urgent care claim appeal be reviewed simultaneously by us and OPM. Please let us know that you would like a simultaneous review either in writing at the time you appeal our initial decision or by calling us at (**888) 789-9065**. You may also call OPM's FEHB 2 at (**202) 606-3818** between 8 a.m. and 5 p.m. (ET) to make your request. In addition, if you did not indicate that your claim was for urgent care, call us at (**888) 789-9065**. If it is determined that your claim is an urgent care claim, we will expedite our review if we have not yet responded to your claim.

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- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call; and/or
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has the right to file a disputed claim with OPM. Parties acting as your representative (such as medical providers) must include a copy of your written consent with the request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Full and Fair Review

You or your authorized representative have the right to ask us to reconsider our claim decisions as described in Section 8 of the CareFirst BlueChoice, Inc., Plan brochure. To help you prepare your request, you may request free copies of all relevant materials and plan documents relating to your claim, including those that involve any expert review(s) of your claim. To make your request, please contact our Customer Service Department by writing to Mail Administrator, P.O. Box 14114, Lexington, KY 40512-4114 or calling (**888) 789-9065**.

We are required to provide you with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim—free of charge and in a timely manner. We will also provide any new rationale for our claim decision. Furthermore, we will identify the medical or vocational experts whose advice we obtained in connection with the initial decision. You will receive this information well before a decision on your appeal is reached, so you have adequate time to respond.

We will consider all new or additional comments, documents, records and other information relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

When our initial decision is based on a medical judgment (i.e., medical necessity, experimental/ investigational), we will consult with a healthcare professional with appropriate training and experience who was not involved in making the initial decision.

If we do not substantially comply with these requirements, you may immediately appeal to OPM as explained above.

Avoiding Conflicts of Interest

Our reconsideration decision will be conducted by a plan representative who was not involved in the initial decision. The new decision will not defer to the initial decision in any way.

We will not make our decisions regarding hiring, compensation, termination, promotion or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) based upon the likelihood that the individual will support the denial of benefits.

If we do not substantially comply with these requirements, you may immediately appeal to OPM as explained above.

Notice Requirements

We must have notices available in your language of choice in accordance with rules determined by the Secretary of Health and Human Services. English notices will include a statement explaining how to access language services. This statement will be written in all applicable languages.

We must also provide oral language services (e.g., telephone customer assistance) that include answering questions and providing assistance with filing claims and appeals in any applicable non-English language. For more information, contact the customer service number on the back of your identification card.

Any notice of an adverse benefit determination or reconsideration confirmation that we send must include sufficient information to identify the claim involved. This includes the date of service, the healthcare provider and the claim amount (if applicable). A statement describing the availability of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning may be requested.