



# ADMINISTRATIVE REVIEW FORM

State Health Benefit Plan  
P.O. Box 38342  
Atlanta, Georgia 30334

## SECTION I.

Employee Name: \_\_\_\_\_ SSN: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP Code: \_\_\_\_\_

Home phone: (     ) \_\_\_\_\_ - \_\_\_\_\_ Work phone: (     ) \_\_\_\_\_ - \_\_\_\_\_

**SECTION II.** Read the Instructions and Requirements on the reverse side of this form as there are time restrictions and limitations as to what may be appealed. Include *copies of all EOB(s) for all claim(s) issues except Prior Approval/Eligibility.*

Claim Number: \_\_\_\_\_ Date(s) of service: \_\_\_\_\_

Charge Amount(s): \_\_\_\_\_

Physician/Hospital/Provider: \_\_\_\_\_

Provider Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

## SECTION III.

Describe the reason for your request (attach additional sheets, if needed). Attach any supporting documentation, such as bill copies, medical records, or the physician statement of medical necessity, related to the review.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**AUTHORIZATION:** I hereby authorize the release of medical and other necessary information for the purpose of evaluating this Administrative Review. I understand that the SHBP may contact other entities on my behalf, and I authorize the SHBP to release such information for the purpose of resolving my Administrative Review. The Health Insurance Portability and Accountability Act (HIPAA) requires that the patient authorize this release unless the patient is under the age of 18.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### FOR DCH USE ONLY

**Tracking Number:**

\_\_\_\_\_

Type of Request:

- ( ) Administrative Review
- ( ) Non-appealable

Area of Review/Appeal:

- ( ) Benefits / Claims processing
- ( ) Medical Certification Program
- ( ) Eligibility / Participation

## INSTRUCTIONS AND REQUIREMENTS

### Items that cannot be reviewed under the Administrative Review process:

- Administrative reviews postmarked more than 180 days from the date of the explanation of benefits for the claim in question.
- The Plan's method of establishing Allowed Amounts.
- A cutback in Allowed Amounts of \$150 or less.
- A Medical Necessity determination made by the MCP, BHS, or Prescription Drug Program clinicians.. *(These must be appealed to the appropriate MCP, BHS or Prescription Drug administrators)*
- Any excluded service or expense.
- Prescription Drug coverage related to whether or not a drug is on the preferred drug list.

**There are three steps in the appeal process, which are described in detail in the April 2003 SHBP booklet, pages 72-75. These steps are the telephone review, Administrative Review and the Formal Appeal.**

### Step I

**For a Telephone Review:** Call Member Services and ask for a review within 90 days of the medical claim denial. If you disagree with the results of the review, you may file a written request for an Administrative Review within 180 days of the explanation of benefits of the claim in question. If this is an eligibility denial, contact the eligibility unit within 90 days of when the Plan advises you that your request cannot be approved.

**Note:** Any issue regarding the Plan's eligibility or participation should first be addressed to the Eligibility Unit and then through the Administrative Review processes. The MCP and BHS also have appeal processes. They should be contacted first before filing an appeal with the SHBP.

All requests for Administrative Review must be in writing on this specially designed form. If an appeal is received without the corresponding form, it will be returned to you with a copy of the form to complete. Oral requests or oral arguments by telephone or in person will not be considered. An acknowledgement letter is sent to you advising of the receipt of your Administrative Review within 72 hours.

### Step II

**Administrative Review:** To file a request for Administrative Review, complete all applicable Sections on this form, sign the form, and send copies of EOB's on the claims in question. Any additional facts or materials that are pertinent to the case should be attached and submitted with this form. The request must be mailed and postmarked within 180 days from the date on the explanation of benefits (EOB) that notified you of the partial or total denial of a claim or a decision concerning eligibility or participation.

### Step III

**Formal Appeal:** If your request for Administrative Review is denied, you may file a Formal Appeal, which must be postmarked within 60 days following the date of Administrative Review decision. To file a Formal Appeal, you must complete the applicable form and attach a copy of the decision of the Administrative Review, MCP or Prior Approval determination. Instructions are on the Formal Appeal form and in the Summary Plan Description.