



Grievances and Appeals

Initial Determinations:

If you have problems getting the Part D drugs and/or Part C medical care or services you need, or payment for a Part D drug and/or Part C service you already received, you must request an initial determination with the plan.

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug and/or Part C medical care or service you need, or paying for a Part D drug and/or Part C medical care or service you already received.

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your appointed representative. To learn how to name your appointed representative, you may call Member Services.

A decision about whether we will give you, or pay for, the Part C medical care or service you are requesting can be a standard decision that is made within the standard time frame, or it can be a fast decision that is made more quickly. A fast decision is also called an expedited decision. If you need additional information, please refer to your Explanation of Coverage or call for more details.

Appeals:

You, or your representative, may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "redetermination. An appeal to the plan about Part C medical care or services is also called plan "reconsideration." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline. Please call (see phone numbers below) or refer to your Explanation of Coverage, Section 8, for more information on how to file an appeal and what happens during the process.

What is a Grievance?

A Grievance is a complaint that does not involve problems related to approving or paying for Part C and Part D drugs, medical care or services, problems about having to leave the hospital too soon, or problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

What types of problems might lead to your filing a grievance?

- . Problems with the service you receive from Member Services.
- . If you feel that you are being encouraged to leave (disenroll from) the Plan.
- . If you disagree with our decision not to give you a “fast” decision or a “fast” appeal.
- . We don’t give you a decision within the required time frame.
- . We don’t give you required notices.
- . You believe our notices and other written materials are hard to understand.
- . Waiting too long for prescriptions to be filled.
- . Rude behavior by network pharmacists or other staff.
- . We don’t forward your case to the Independent Review Entity if we do not give you a decision on time.
- . Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- . Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- . Problems getting appointments when you need them or waiting too long for them.
- . Rude behavior by doctors, nurses, receptionists, or other staff.
- . Cleanliness or condition of doctor’s offices, clinics or hospitals.

You or someone you name may file a grievance. The person you name would be your representative. You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative or if you need any assistance, call Member Services at 1-866-690-4842.

Contact Information for Grievances, Organization Determinations & Appeals

Part C Organization Determinations

Pre-service/Authorizations

CALL	866-690-4842 ext. 2989
TTY/TDD	1-800-617-0177
FAX	866-420-4842
WRITE	Universal Health Care, Inc. Attn: Utilization Management 100 Central Avenue, Suite 200 St. Petersburg, FL 33701

Claims

CALL 1-866-690-4842
TTY/TDD 1-800-617-0177
FAX 727-456-7860
WRITE Universal Health Care, Inc.
Attn: Claims
P.O. Box 294
St. Petersburg, FL 33701-1964

Part C Grievances

CALL 1-866-690-4842
TTY/TDD 1-800-617-0177
FAX 727-821-1894
WRITE Universal Health Care, Inc.
Attn: Grievance & Appeals
P.O. Box 1964
St. Petersburg, FL 33701-1964

Part C Appeals

CALL 1-866-690-4842
TTY/TDD 1-800-617-0177
FAX 727-821-1894
WRITE Universal Health Care, Inc.
Grievance & Appeals Dept.
P.O. Box 1964
St. Petersburg, FL 33701-1964

Part D Coverage Determinations

CALL 1-800-753-2851
TTY/TDD 1-800-716-3231
FAX 1-888-235-8551
WRITE Medco Health Solutions, Inc.
ATTN: Medicare Reviews
P.O. Box 630367
Irving, TX 75063-0118

Part D Reimbursement Requests

CALL **1-800-753-2851**
TTY/TDD **1-800-716-3231**
FAX 1-888-235-8551
WRITE Medco Health Solutions, Inc.
 Attn: Medicare Reviews
 P.O. Box 630367
 Irving, TX 75063-0118

Part D Grievances

CALL **1-866-690-4842**
TTY/TDD **1-800-617-0177**
FAX 727-821-1894
WRITE Universal Health Care, Inc.
 Attn: Grievance & Appeals
 P.O. Box 1964
 St. Petersburg, FL 33701-1964

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