HEALTH PLAN ADMINISTRATOR: Sidecar Health Insurance Solutions, LLC	**TELEPHONE:** 855-346-4846 **FAX:** 866-376-2053
MAILING ADDRESS: 440 N Barranca AVE #7028 Covina, CA 91723	**EMAIL ADDRESS:** claims@sidecarhealth.com **WEBSITE ADDRESS:** www.sidecarhealth.com

THIS DOCUMENT CONTAINS IMPORTANT INFORMATION THAT YOU SHOULD RETAIN FOR YOUR RECORDS

This document contains information on your rights in the event we decline to pay a benefit amount for an item or service. This could happen if we determine the item or service is not medically necessary, you are not eligible for the benefit, or the benefit is not covered under your plan. You have the right to an appeal if you think a decision to not pay a benefit for an item or service was made in error.

Important Information about Your Appeal Rights

Where can I find an explanation of my claim? Each claim has its own Expense Detail Page within the Member Portal at www.sidecarhealth.com. In the Expense Detail Page, you can view a summary of each item or service included in the claim, the provider's charge, the Benefit Amount, the total covered by your policy, and any uncovered portion.

What if I need help understanding a claim decision? If you need assistance understanding this notice or any decision of ours regarding a claim, please contact us at:

Phone Number: 855-346-4846

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

Can I provide additional information about my claim? Yes, you may supply additional information. Please forward your information to any of the following addresses:

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at:

Phone Number: 855-346-4846

Fax Number: 866-376-2053

Email Address: claims@sidecarhealth.com

Mailing Address: 440 N Barranca AVE #7028, Covina, CA 91723

What if I don't agree with a claim decision? You have a right to appeal any decision of ours to not pay any benefit amount for an item or service.

How do I file an appeal? Complete the Appeal Request Form, keep a copy for yourself and send the form to us at any of the following addresses:

Fax Number: 866-376-2053

Email Address: grievances@sidecarhealth.com

Mailing Address: Attn: Grievances, 440 N Barranca AVE #7028, Covina, CA 91723

Who may file an appeal? You, someone you authorize, or someone who is authorized by law to act for you (your authorized representative) may file an appeal. Please complete the Appointment of Authorized Representative section of the Appeal Request Form.

What happens next? If you request an appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage or service requested or you do not receive a decision within 30 days, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

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Request for Internal Appeal

Name of person filing appeal: _____

Relationship to covered person: ❒Covered Person/Applicant

❒Authorized Representative ***(please complete the Appointment of Authorized Representative section)***

How would you like us to contact you? ❒Phone ❒Fax ❒Email ❒Mail

Contact information of authorized representative (if applicable)

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Covered Person/Applicant Information

Name: ID Number:

Mailing Address:

Daytime Phone: Evening Phone:

Email Address: Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

Email Address: Fax Number:

Contact Person: Phone Number:

Internal Appeal Specifications

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim):

_____

_____

_____

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Request for Internal Appeal

Appointment of Authorized Representative (complete when someone else is representing you in this appeal)

You may represent yourself, or you may ask another person, including your treating healthcare provider, to act as your authorized representative. You may revoke this authorization at any time.

I hereby authorize _____ to pursue my appeal on my behalf.

_____

Signature of Covered Person (or legal representative**) Date

Signature and Release of Medical Records

To appeal the denial of coverage, you must sign and date this Appeal Request Form and consent to the release of medical records.

I _____ hereby request an appeal. I attest that the information provided on this form is true and accurate to the best of my knowledge. I authorize my treating physician, healthcare provider, and/or health plan issuer to release all relevant medical or treatment records to an independent review organization and/or my health plan issuer. I understand that the independent review organization and/or my health plan issuer will use this information to make a determination on my appeal and that the information will be kept confidential and not be released to anyone else. This release is valid for one year. I understand that I or my authorized representative is entitled to receive a copy of this authorization.

_____

Signature of Covered Person (or legal representative**) Date

***Parent, Guardian, Conservator or Other - please specify*

SEND THIS FORM AND A COPY OF YOUR NOTICE OF ADVERSE BENEFIT DETERMINATION TO ONE OF THE FOLLOWING ADDRESSES:

Fax Number: 866-376-2053

Email Address: grievances@sidecarhealth.com

Mailing Address: Attn: Grievances, 440 N Barranca AVE #7028, Covina, CA 91723

Be certain to keep copies of this form, your Notice of Adverse Benefit Determination and all documents and correspondence related to this claim.