sidecar health

Notice of Adverse Benefit Determination

HEALTH PLAN ADMINISTRATOR: Sidecar Health Insurance Solutions, LLC	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 of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision we make to not fully pay for an item or service. This could be because the charge for the item or service exceeds the specified Benefit Amount. We may also make a decision to not pay for an item or service if we determine it is not medically necessary, or 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 fully pay for an item or service was made in error (see the Important Information About Your Appeal Rights section of this notice).

How To Contact Us

If you need assistance understanding this notice or any decision of ours regarding a claim, please message us through the Sidecar Health Member Portal or contact us at:

Fax Number	Phone Number	Mailing Address
866-376-2053	855-346-4846	440 N Barranca Ave # 7028, Covina, CA 91723

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. In the Expense Detail Page, you can view a summary of each item or service included in the claim.

Can I provide additional information about my claim? Yes, you may supply additional information by messaging us through the Sidecar Health Member Portal or sending your information to us by fax or mail, with Attn: Claims.

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 any of the methods listed above.

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

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How do I file an appeal? Complete the Appeal Request Form, keep a copy for yourself and either fax the form to us or mail the form to us, with Attn: Grievances.

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. Please refer to the attached External Review Procedures Summary for more information.

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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 ❒Member Inbox ❒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:

Fax:

Treating Physician/Healthcare Provider Information

Name:

Mailing Address: Phone Number:

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, the Ohio Department of Insurance, and/or my health plan issuer. I understand that the independent review organization, the Ohio Department of Insurance, 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

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.