Important Facts About

Your Internal Appeal Rights

SANFORD HEALTH PLAN

What if I need help understanding a denial and my rights?

For help with this notice or our decision not to pay for an item or service, call us toll-free at (855) 305-5060 | TTY/TDD (877) 652-1844. We are open from 8 a.m. to 5 p.m. CT, Monday to Friday. If you need free help in a language other than English, call toll-free (800) 892-0675.

What if I don't agree with a decision?

You have the right to appeal any part of a decision not to provide or pay for an item or service. If you disagree with a decision, you have **60 calendar days** from the date we sent this denial to tell us you want to appeal. If you would like to keep getting the services or benefits we denied while you appeal, you must tell us you want to appeal within **10 calendar days** of getting this notice. You may be required to pay the cost of health care services provided during your appeal if the final decision says your benefits will be denied.

How do I file an appeal?

You or your provider can appeal by calling or writing us. If you decide to appeal by calling, we will use the date you call as the filing date for your appeal. Unless you have an urgent (fast) appeal, **if you call to appeal, you also need to send us a written appeal, signed by you.**

To appeal in writing, send us a letter or use the Appeal Filing Form. We will let you know when we receive your appeal, usually by mailing you a letter.

Who may file an appeal?

You, or someone you tell us in writing is allowed to speak for you, like a doctor or family member, may file an appeal. This person is known as your authorized representative. If the person who was denied a benefit or service has died, their estate's legal representative may file an appeal.

Can I give more facts about my appeal?

Yes, you can give us more details, including records or notes you would like considered in your appeal. You can give these facts in person, by calling us, or sending copies of items you want included. Keep copies of all paperwork you send us.

Can I get copies of papers related to my appeal?

Yes, you can get free copies. If you think a coding error may have caused a claim to be denied, you have the right to get billing codes sent to you for free. To get copies, call us or send us a secure message through the Member Portal at sanfordhealthplan.com/memberlogin.

What if I need an urgent (fast) appeal decision?

If you or your provider think your need is urgent, tell us when you file your appeal. Generally, an urgent situation is when your health may be in serious danger, or if your doctor believes your pain cannot be well controlled while you wait for a decision on your appeal.

If we deny your request for an urgent (fast) review, we will call you and also mail you a letter explaining this decision within 24 hours. Your appeal will then follow the standard appeal decision timeframe. If you disagree with our denial of your request for an urgent review, you may file a complaint with us.

What happens next?

For standard appeals, we will make a decision within 30 calendar days from the day we receive your appeal. We will make a decision on an urgent (fast) appeal within 72 hours. If you do not agree with our decision on your appeal, you may have the right to request a State Fair Hearing. Appeals for Non-covered Service Determinations are not eligible for State Fair Hearings.

What if I need help with my appeal?

We will help you fill out appeal paperwork and can assist you in other ways to understand the appeal filing process. We can read forms to you over the phone.

North Dakota Medical Services can also help:
Phone: (844) 854-4825 (toll-free)
ND Relay TTY: (800) 366-6888 (toll-free)

Contact Us:

Sanford Health Plan
Attention: Appeals
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: (877) 652-8544
Fax: (605) 312-8910

Appeals and Denials Department
Phone: (877) 652-8544
Fax: (605) 312-8910
sanfordhealthplan.com

SANFORD HEALTH PLAN

Appeal Form

Member name: _____
First Middle Last

Member ID# from your ID card: _____Date of birth: _____

Name of person filing appeal: _____

Check one: ☐ Self (Patient) ☐ Authorized representative (Family/Caregiver) ☐ Provider/Doctor

Contact information for person filling out this form:

Address: _____

Email: _____ Daytime phone: _____

If the person filling out this form is other than the patient/member, the patient must give permission for the appeal by signing here:

_____
Patient Signature

Do you need an urgent (fast) appeal? ☐ Yes ☐ No

Do you want the services being appealed to continue while you appeal? ☐ Yes ☐ No

* If you would like to keep getting the services or benefits we denied while you appeal, you must appeal within **10 calendar days** of the date on your denial notice
* You may be required to pay the cost of health care services provided during your appeal if the final decision says your benefits will be denied

Tell us the decision you disagree with:

Date(s) of Service: _____ Referral #(s): _____

What provider(s) did or will you see? _____

What services or procedures did or will you get? _____

Tell us why you don't agree with this decision (please attach medical records, or other facts, to support your case):

_____

_____

_____

Send this form and your denial notice to:
Sanford Health Plan, Attention: Appeals
PO Box 91110 Sioux Falls, SD 57109-1110
Phone: (877) 652-8544 | Fax: (605) 312-8910

Keep copies of this notice and all other documents related to this request.