Grievance, Organization/Coverage Determinations and Appeals

GuildNet Gold HMO SNP is a coordinated care plan with a Medicare Advantage contract and a contract with the New York Medicaid program. We are committed to providing you with the high quality services you deserve and improving member satisfaction. If you have a complaint related to our plan, providers, or pharmacies, please call our Member Services Department at 1-800-815-0000 (TTY users should call 711), Monday – Sunday 8:00am to 8:00pm and we will do our best to assist you over the phone. You can also write to us at 250 West 57th Street, 10th Floor, New York, NY 10107, fax to 646-619-6093 or go to https://www.medicare.gov/MedicareComplaintForm/home.aspx to file an electronic complaint directly with Medicare.

Complaints and Appeals

Our members have the right to make complaints and ask us to reconsider decisions we have made. When you have a problem about our decision related to benefits, coverage or payment, you can file an *appeal* and we will reconsider our decision. When you have other problems related to your quality of care, our plan, providers or pharmacies, you can file a *grievance***.**

You can also refer to Chapter 9 of the Evidence of Coverage available on our website www.guildnetny.org.

Grievances

You or your ***appointed representative*** may file a grievance to our plan by calling our Member Services number at 1-800-815-0000 (TTY users should call 711), Monday through Sunday, 8 a.m. to 8 p.m., by fax to 646-619-6093 or in writing to 250 West 57th Street, 10th Floor, New York, NY 10107. If we cannot resolve your issue over the phone, we will resolve it as quickly as possible, but no later than thirty (30) calendar days from the date our plan receives your request. We may take more time, up to fourteen (14) days, if we need additional information. We will notify you of our decision in writing.

Sometimes we must make a decision within 24 hours of receipt of your complaint. We will make a fast decision on a complaint if your health requires it or when you complain about our decision to take extra time or deny your request for a fast decision about a request or appeal for service. We will notify you of our decision by phone and in writing.

Coverage Decisions

We make coverage decisions whenever we decide what is covered for our members or how much the plan will pay. Coverage decisions may also involve issues related to payment for services or drugs already obtained. We handle decisions about medical coverage differently from prescription drug coverage decisions.

Organization Determinations

Organization Determinations are coverage decisions we make on medical services (for example, hospital stay and doctor or outpatient services). We must make a decision on a request for a service or item as soon as your health requires it, but no later than 14 days from the date we receive it. You can request an expedited (fast) determination if you or your doctor believe that your health could be seriously harmed by waiting for a standard decision. If your request to expedite is granted, we must give you a decision no later than 72 hours after we get your request. Sometimes we may take up to 14 additional days to complete a review. Should this happen we will tell you when we will make our decision. You also have a right to request a payment for services you may have already received. We will inform you of our final decision in writing.

To request an Organization Determination you, your provider or authorized representative should call us at 1-877-833-2729, TTY 711 Monday through Sunday 8 am to 8 pm, contact us by fax to 646-619-6093. Or write to GuildNet Gold, c/o EmblemHealth Medicare PPO, ATTN: Utilization Management, 55 Water Street, 2nd Floor, New York, NY 10041.

Coverage Determinations (this includes Exceptions)

A Coverage Determination is our decision to pay or cover your Part D drug, this includes a formulary, tiering or utilization restriction exception. Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) determination if you or your prescriber believe that your health could be seriously harmed by waiting for a standard decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get your prescriber's or prescribing physician's supporting statement.

Generally, GuildNet will only approve your request for an exception if the alternative drugs included on the plan's formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects. When you are requesting an exception you should submit a statement from your physician or prescriber supporting your request. You can use the form available on our website.

To request a coverage determination you, your prescriber or authorized representative should use a request form available on our website and fax it to 877-300-9695 or call us at **1-877-444-3973** (TTY 711) Monday through Friday 8 am to 8 pm. You can also write to GuildNet Gold Pharmacy Services, 55 Water Street, New York, NY 10041. Use the number and address above

to make a request for payment for a Part D drug that you already received.

Appeals

What is an Appeal?

An appeal is the action you can take if you disagree with a coverage or payment decision we made. You must make the appeal request within 60 calendar days from the date of the coverage decision letter we sent you. You can make an appeal if we deny:

- A request for a health care services, supplies, or prescription drugs that you think you should get;
- A request for health care services, supplies or prescription drugs you already got that was denied;
- A request to change the amount you must pay for a prescription drug.

How to Request an Appeal

You can request a standard appeal of coverage or organization determination. We must give you a decision no later than 7 days after receiving your prescription drug and 30 days after receiving your medical appeal.

You can request an expedited (fast) appeal of coverage or organization determination if you or your doctor believe that your health could be seriously harmed by waiting for a standard appeal. We will automatically expedite your request, if your provider asks us to. If your request to expedite is granted, we must make a decision no later than 72 hours after receiving your appeal.

If you make an appeal of denial of payment for a service, we must make a decision within 60 days. However, we may ask for more time to review your case. We will inform you in writing should this happen.

To request an appeal you can write to GuildNet Gold ATTN: Appeals and Grievances, PO Box 2807, New York, NY 10116-2807 or fax your request to 212-510-5320 or call **1-855-283-2148** (TTY 711). Use the number and address above to make a request for payment for a Part D drug that you already received.

Who May Request an Appeal?

You or someone you name to act for you (your **appointed representative**) may request an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others may already be authorized under State law to act for you. Complete the Appointment of Representative Form available on our website. You can fax or mail the form to us at the number or address listed above.

What Do I Include with My Appeal Request?

You should include your name, address, Member ID number, the reasons for appealing, and any evidence you wish to attach. If your appeal relates to a decision by us to deny a drug that is not on our formulary, your prescribing physician must indicate that all the drugs on any tier of our formulary would not be as effective to treat your condition as the requested off-formulary drug or would harm your health.

What Happens Next?

If any of the prescription drugs or medical services you requested are still denied, you can request an independent review of your case by a reviewer outside of our plan. We will automatically forward your denied appeal to an independent review for medical services. If you disagree with that decision, you will have the right to further appeal. You will be notified of your appeal rights if this happens.

For services covered by our plans under Medicaid, you may have additional Medicaid appeal rights. Please call Member Services or see your Evidence of Coverage for more information.

Please call our Member Services Department at 1-800-815-0000 (TTY users should call 711), Monday – Sunday 8:00am to 8:00pm, if you have any questions.

GuildNet Gold is a HMO SNP plan with a Medicare and New York State Medicaid contract. Enrollment in GuildNet Gold depends on contract renewal.

This information is available for free in other languages. Please contact our Member Services number at **1-800-815-0000 (TTY users should call 711)** for additional information. Hours are Monday through Sunday, 8 am to 8 pm. Member Services also has free language interpreter services available for non-English (phone numbers are printed on the back cover of this booklet).

Esta información está disponible en otros idiomas a gratis. Por favor llame a Servicio para los Miembros, al **1-800-815-0000 (Los usuarios de TTY deben llamar al 711)** para obtener información adicional. Se atiende lunes a domingo, 8 am a 8 pm. Servicio para los Miembros tienen servicios gratuitos de intérprete de idioma disponibles para altavoces de no-inglés.