Insurance Claim Appeal Process

Overview

The following are the appeal procedures to follow when dissatisfied with a claim determination.

Initial Review of Claim Determination

A plan participant who believes an error has been made in the benefit amount allowed or disallowed must contact the appropriate managed care plan or plan administrator within 180 days of the date of the initial claim determination.

A customer service representative will be able to provide more information regarding the denial. In some cases, additional information such as an operative report or x-rays may be required to determine if additional benefits are available. In some cases, a special review by a physician or dentist may be warranted. Each case will be analyzed and considered on its own merits.

If dissatisfied with the outcome of the review, plan participants are entitled to file a grievance or appeal. Contact the appropriate managed care plan or plan administrator for information on the procedure. The managed care plan´s or plan administrator´s internal review process must be used to the fullest extent prior to contacting the CMS/Group Insurance Division regarding a final determination.

Final Claim Determination

If, after the managed care plan´s or plan administrator´s review, a plan participant still feels that the claim determination is not in accordance with the published benefit coverage, a Final Determination by the CMS/Group Insurance Division may be requested within 60 days of the date of the Initial Review determination. The request must be in writing from the plan participant and be accompanied by all medical/dental documentation supporting the reasons for reconsideration of the benefit determination.

Submit Documentation to:

Central Management Services
Member Services
801 S. 7th Street
PO Box 19208
Springfield, IL 62794-9208

Appealing the Final Claim Determination

If a plan participant is still not satisfied, an appeal of the Final Determination may be made to an appeal committee within 60 days of the Final Review determination. This committee will review the documentation and facts presented in the Final Determination.

The appeal committee will consider the merits of each individual case. If new information is presented to the committee which was not presented during the Final Determination, the appeal will be returned to the CMS/Group Insurance Division for review and reconsideration of the determination.

Plan participants will be notified in writing of the outcome of the committee´s review. The decision of the appeal committee shall be final and binding on all parties.

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