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How to Appeal our Determination State of New Hampshire Employee Group Health Plan

If you are dissatisfied with the recent determination we issued, you, your practitioner, or any other authorized representative you choose may file an appeal. If you designate a representative, please provide that representative with a signed authorization to include with the appeal. You may appeal benefits denials that are administrative (contractual denials of excluded or limited services) or clinical (services denied due to medical necessity criteria). You must file an appeal within 365 days of the date we issued the adverse determination you are appealing.

You may request that the clinical appeal process be expedited if the time frames under this process would seriously jeopardize your life, health, or ability to regain maximum functionality or in the opinion of your Physician would cause you severe pain which cannot be managed without the requested services. An expedited review will be completed within 72 hours after the request is initiated. The determination will be relayed via telephone, with written communication to be issued within two business days. The request may be initiated by the covered person or the provider acting on behalf of the covered person.

What should your appeal include?

Identify (by patient name, certificate or identification number, provider of care, date of service, and, if available, by claim number) the specific determination with which you disagree. Explain the specific reason(s) why you do not agree with our determination. Please include all pertinent information regarding the care under appeal, including the names of health care providers who may have pertinent records, as well as any additional supporting documentation you would like us to review.

How do you file an appeal?

- In writing to our Appeal Analyst, PO Box 518, North Haven, CT 06473-0518
- If you need assistance or if you are unable to send your appeal in writing, you may call the telephone number on the back of your health plan ID card

How will your appeal be handled?

Our appeal analyst will review the entire record of your appeal, including any additional supporting documentation you submit with your appeal, and will research and respond to the issues you have raised. All determinations of medical necessity or clinical appropriateness will be considered by a health care professional with expertise to review your case. We reserve the right to request records from any providers who may have relevant documentation. Please be advised that health care providers may require your signed authorization before they release medical records. For pre-service or concurrent care coverage determinations, we will issue a written decision within 15 calendar days of receiving your request for appeal. For post-service coverage determinations, the decision will be issued within 30 calendar days.

If you disagree with the determination on your appeal, can you appeal further?

Yes. Along with our determination, we will provide you with information on how to appeal further, and other rights available to you. Because the State of New Hampshire benefit program is self-funded, the New Hampshire Insurance Department does not regulate Anthem in its administration of this coverage. If you are not satisfied with the outcome of your final level appeal, or if you believe at any time that Anthem is not following the appeal process as it has been described in the Benefits Booklet or in your communications with Anthem, you should contact the State of New Hampshire Division of Personnel.