SOLIS HEALTH PLANS

Appeal or Grievance Request Form

If something didn't go as expected with your Solis plan or your care, we want to know. Use this form to explain what happened and how we can help resolve the issue. Please include as much information as you can so we can fully review your concern.

You can send this form, along with any helpful documents (such as medical records, bills, an Explanation of Benefits, or a letter from your doctor), by mail or fax.

Please note that your benefits will continue during this grievance/appeal process if you remain enrolled in Solis. If you need assistance completing this form or have any questions regarding it, please call Member Services at **1-844-447-6547**, TTY 711, from 8 a.m. to 8 p.m. seven days a week from Oct. 1 – March 31 and 8 a.m. to 8 p.m. Monday - Friday from April 1 - Sept. 30.

Member Information		
Member Name:		**Date of Birth:**
Solis ID Number:		**Medicare Number:**
Address:		**City:**
State:	**ZIP Code:**	**Phone Number:**
Email Address:		**Additional Phone Number:**

Issue Details
To help us better assist you, please check the box below that best describes your concern: ☐ A medication (prescription drug) ☐ A medical service or equipment ☐ An issue that is not related to a specific medication or medical service
Service or Medication Name/Description:
Provider Name (Doctor/Facility/Prescriber):
Have you already received the medical service or medication? ☐ Yes ☐ No
Date of Service or Event (if applicable):
Claim Number (if applicable): **Authorization Number (if applicable):**

Issue Details (Continued)

Is this an appeal or a grievance?

☐ **Appeal** *(You are asking us to review a decision we made about coverage or payment for a service, item, or prescription medication.)*

Does your appeal need to be reviewed quickly? If you, your physician, or prescriber think that waiting for a standard decision could harm your life, health, or ability to regain maximum function, you may request an expedited (fast) appeal.

Expedited appeals are only available for services or drugs you have not yet received. You can request an expedited appeal verbally or in writing.

□ *Please check this box if you are requesting an expedited decision within 72 hours.*

Standard appeal decision timeframes are:

- 7 calendar days for Part B or Part D prescription medication appeals
- 30 calendar days for medical pre-service or equipment appeals

If your physician or prescriber states that waiting for a standard decision could seriously harm your health, your appeal will automatically be processed as expedited. If a supporting statement from your physician or prescriber is not provided, we will determine whether your appeal qualifies for expedited review.

☐ **Grievance** *(You are unhappy with something other than a coverage decision, such as customer service, access to care or quality of care.)*

Below please explain your grievance/appeal, please include any information you feel should be considered in the review of your grievance/appeal. Use additional sheet(s) if necessary. Please attach any document(s) that you feel should be reviewed.

Supporting Documentation:

You may include copies of any documents that support your request, such as:

- Medical records
- Medical bills
- Explanation of Benefits (EOB)
- Letters from your provider or pharmacy

☐ Documents attached ☐ No documents attached

Appointing a Representative (Optional)

If someone is helping you file this grievance or appeal, please complete the information below.

Representative Name:

Relationship to Member:

Phone Number:

☐ I authorize this person to act on my behalf regarding this grievance or appeal.

If someone is acting on your behalf, you must include a completed Appointment of Representative (AOR) form or other legal documents that show they are authorized to represent you (such as a Power of Attorney for Health Care). The AOR form must be signed by you and the person you are appointing and sent to the plan. You can get this form from Member Services, the Medicare website, or the Solis Health Plans website.

I HEREBY request a review of the grievance/appeal described above and understand that the receipt of this Appeal or Grievance Form by Solis constitutes a request for review.

I understand that for Solis to review my appeal/grievance, Solis may need medical or other records or information relevant to my appeal/grievance.

Accordingly, I authorize persons or entities that have any medical or other records or knowledge of me to release such information to Solis for Solis to complete its review of my appeal/grievance.

This information will not be released to any other organization or individual except as permitted under Federal and State Law, pursuant to court orders or subpoenas. Solis has established appropriate safeguards to ensure the privacy and confidentiality of all medical information and to prevent unauthorized access to it

Member Signature:	**Date:**
Representative Signature (if applicable):	**Date:**

Please mail or fax this signed form to:

Mail:

Solis Health Plans
Attn: Grievance/Appeals Department
PO Box 524173
Miami, FL 33152

Fax:

833-615-9263

Timeframes for Responses	
Below are the timeframes in which you will receive a response to your grievance or appeal, based on the type of request submitted.	
Type of Request	**Response Time**
Expedited (Fast) Appeal *(Prescription drug or medical service)*	Within 72 hours
Standard Prescription Drug Appeal - Authorization *(Example: You are requesting approval for a medication you have not yet received.)*	7 calendar days
Standard Prescription Drug Appeal - Claim *(Example: You have already received the medication.)*	14 calendar days
Standard Medical Service Appeal - Authorization *(Example: You need approval before receiving a medical service.)*	30 calendar days
Standard Medical Service Appeal - Claim *(Example: You have already received the medical service.)*	60 calendar days
Expedited (Fast) Grievance *(Example: We determined your appeal does not qualify as expedited, or we extended the appeal decision by 14 days, and you disagree.)*	Within 24 hours
Standard Grievance *(Example: You are dissatisfied with the quality of care or service by the plan or a provider.)*	30 calendar days