UnitedHealthcare Community Plan

Changes to Member Appeal Process

As a participating UnitedHealthcare Community Plan care provider, you may occasionally submit appeals on behalf of our members. Because of this, we want to make you aware that beginning **July 1, 2017,** we will alter the New Jersey Managed Care Organization member appeal process for denials of health care services to mirror changes to the federal rules that we are required to follow.

What Is Changing
Here are the highlights of the changes to the member appeal process:

- **We will shorten the timeframe to request an Internal (Stage 1 or Level 1) Appeal from 90 days to 60 calendar days;**
- **We will eliminate the Stage 2 or Level 2 Appeal;**
- **We will shorten the timeframe to request an Independent Utilization Review Organization (IURO) Appeal (previously known as a Stage 3 or Level 3 Appeal) from four months to 60 calendar days;**
- **We will extend the timeframe to request a Medicaid Fair Hearing from 20 calendar days to 120 calendar days**

What This Means To Members

If members need to request an appeal for a denial of a health care service, they will receive the appropriate letter from us at each stage or level of their appeal. The letters will guide the member through the process. Members can also call us if they have any questions.

We're Here To Help
If you have questions or need more information, please call Member Services toll-free at 800-941-4647, TTY 711, 8 a.m. to 6 p.m. ET, Monday through Friday. The toll-free phone number is also listed on the back of any UnitedHealthcare Community Plan of New Jersey member's ID card.

Please continue to the next page for an example of the member letters – in English and Spanish.

June 8, 2017

OUR APPEAL PROCESS IS CHANGING!

Dear Member:

Thank you for being our member!

Beginning July 1, 2017, the New Jersey Managed Care Organization appeal process for denials of health care services will be different because of changes to the federal rules that we must follow. Here are the highlights:

- **The timeframe to request an Internal (Stage 1 or Level 1) Appeal will be shortened to 60 calendar days (from 90 days);**

- **The Stage 2 or Level 2 Appeal will be eliminated;**

- **The timeframe to request an Independent Utilization Review Organization (IURO) Appeal (previously known as a Stage 3 or Level 3 Appeal) will be shortened to 60 calendar days (from four months);**

- **The Timeframe to request a Medicaid Fair Hearing will be extended to 120 calendar days (from 20 calendar days)**

Please be assured that, should you need to request an appeal for a denial of a health care service, you will receive the appropriate letter from us at each stage or level of your appeal. The letters will guide you through the process. You can also call us if you have any questions.

If you have any questions now, or require further information, please call us at (Toll-Free Health Plan Number; TTY: 711).

Again, thank you for being our member.

Sincerely,

Health Plan Closing

8 de junio de 2017

¡NUESTRO PROCESO DE APELACIÓN ESTÁ CAMBIANDO!

Estimado Miembro:

Gracias por ser nuestro miembro.

A partir de julio 1, 2017, se producirán cambios en el proceso de apelación de la Organización de Atención Administrada de New Jersey para las denegaciones de los servicios de atención de la salud, debido a que debemos acatar las normas federales. Los siguientes son los más importantes:

- **El plazo para solicitar una Apelación Interna (Nivel 1) será acortado a 60 días calendario (era de 90 días);**

- **La Apelación de Nivel 2 será eliminada;**

- **El plazo para solicitar una Apelación ante una Organización de Revisión de Utilización Independiente (Independent Utilization Review Organization, IURO) —que anteriormente era una Apelación de Nivel 3— será acortado a 60 días calendario (era de cuatro meses);**

- **El plazo para solicitar una Audiencia Imparcial de Medicaid se extenderá a 120 días calendario (era de 20 días calendario).**

Tenga la certeza de que, en caso de tener que solicitar una apelación para una denegación de un servicio de atención de la salud, le enviaremos la carta correspondiente a cada nivel de su apelación. Las cartas lo guiarán durante el proceso. También puede llamarnos si tiene alguna pregunta.

Si tiene alguna pregunta ahora, o si necesita más información, llámenos al (Número de Teléfono Gratuito del Plan de Salud; TTY: 711).

Nuevamente, gracias por ser nuestro miembro.

Atentamente,

Cierre del Plan de Salud