Member Appeals & Grievances (A&G)

Quick Reference Guide

nh healthy families™

Medicaid A&G Fax:
866-270-9943

Ambetter A&G Fax:
877-851-3992

Telephone:
866-769-3085, x65003 (Dept VM)

Appeal	A request for the Plan to reconsider a previous decision regarding an adverse determination (denial/adverse action).
Initiate	**Medicaid:** Must be filed within 60 days from denial **Ambetter:** Must be filed within 180 days from denial **Expedited:** Can be requested verbally or in writing **Standard:** Must be followed up in writing
Necessary information	*Who* is filing the appeal? *Who* is the appeal for? *What* is being appealed? *Why* are they appealing (i.e., why is the service necessary?) *Supporting clinical documentation is usually helpful
Member Consent	**Medicaid:** Member Consent required in writing for anyone appealing on behalf of the member. Appeal is considered received when member consent is received. **Ambetter:** Member Consent required in writing for anyone appealing on behalf of the member. Appeal is considered received when member consent is received. ***Member Consent is not required when the member requests the appeal or when the appeal is Expedited***
Resolution timeframe	**Expedited:** • 72 Hours (*expedited may be requested but it may not meet the criteria for expedited review) • 24 Hours for Non-Formulary Drug Appeals (Ambetter only) **Standard:** • **Medicaid:** 30 calendar days from receipt • **Ambetter:** 30 calendar days from receipt (45 calendar days from date of notification if missing info) • 72 Hours for Non-Formulary Drug Appeals (Ambetter only)
Follow up	All appeals will be acknowledged and resolved in writing.
Grievance	An expression of dissatisfaction about any matter other than an "adverse action"†. May also be referred to as a complaint.
Initiate	**Medicaid:** Can be submitted verbally or in writing. No filing limit. **Ambetter:** Must be in writing and filed within 180 days.
Necessary information	*Who* is filing the grievance? *Provider can file a grievance on the member's behalf with the member's written consent/signed authorized representative form *Who* is the grievance regarding? *What* is being complained about? *Where & When* did the incident happen? *What* is the expected resolution?
Resolution timeframe	**Medicaid:** 45 calendar days from the date of receipt. **Ambetter:** 30 calendar days from the date of receipt. *Clinically urgent grievances will be resolved no later than 3 calendar days from receipt*
Follow up	All grievances acknowledged & resolved in writing.

†A decision by the Health Plan to deny or limit a requested authorization or service. The Plan's failure to make a decision within a required timeframe, or the member being unable to access health care services in a timely manner are also adverse actions.