

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, Virginia 23466-2876

Dear Member:

Thank you for your request for information regarding the Plan's Complaint process. Please refer to your member materials for a detailed description of the Plan's complaint and appeals process. Enclosed you will find the following information to help guide you should you choose to file a complaint:

- Complaint Form;
- Information on Resolving Complaints;
- Designation Authorization Form (To appoint someone such as a physician or family member to act on your behalf in filing a complaint or appeal);
- Release of Information (This form is used so that the Plan can assist you in obtaining pertinent medical information from practitioners or providers in which health care services have been delivered).

In order for the Plan to address your concerns, your complaint must be submitted within 180 days from the date of your concern with care, service and/or policies and procedures of the Plan. Please send the completed Complaint Form and any additional information related to your concerns to:

Optima Health
APPEALS DEPARTMENT
P.O. Box 62876
Virginia Beach, VA 23466-2876
OR
Facsimile: (757) 687-6232

You will be notified in writing within 5 business days that your information was received and the time required to research your concerns. Procedures for handling complaints and the associated time frames for resolving complaints will vary by the type of complaint received.

Toll-free facsimile: (866) 472-3920

Your continued satisfaction with the Plan is our primary concern. If you have any questions regarding your complaint, please call the Appeals Department at (757) 687-6230.



Optima Health APPEALS DEPARTMENT P.O. Box 62876 Virginia Reach Virginia 23466-2876

OPTIMA FAMILY CARE/FAMIS COMPLAINT FORM

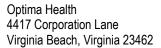
Today's Date:	
	Member's Name:
	Work#:
Date(s) of Service:	Provider/Facility:
Please describe the circumstances	regarding your complaint. Use additional paper if needed.
Signature	Date



Optima Health APPEALS DEPARTMENT P.O. Box 62876 Virginia Beach, Virginia 23466-2876

A Member has the right to designate an authorized representative, such as a physician or family member, to act on his or her behalf in filing a complaint or an appeal of an Adverse Benefit Determination. This authorization may be granted for a particular event or date of service after which time the authorization is revoked, or may be granted for any present or future claim for health care benefits. Explanation of Benefits statements will not be directed to an authorized representative, but will continue to be sent to the Member. To designate an authorized representative, please complete this form and return to the Appeals Department.

Designation Authorization Form							
Member Name:							
Member ID:		Date of Birth:					
Health Plan:		Optima Health Plan (OHP) Sentara Health Plans,Inc. (SHP)		Optima Health Insurance Company (OHIC) Optima Family Care (SFC) FAMIS			
I hearby designa	te:						
		Name		Relationship			
		Address					
		City, State, Zip		Daytime Phone #			
to act on my beh	alf ir	n pursing a claim for benefits or an a	ppea	I of an adverse benefit determination.			
		lid fordays (Consentil revoked by me.	nt is v	valid for <u>180 days</u> unless noted otherwise.)			
above stated pur I agree that a pho authorization sha	pose otog III be	e, I understand that my authorized re raphic copy of this authorization sha e valid for a period of 180 days, unles	epres Il be ss oth	at any time. Also, upon fulfillment of the entative or I may receive a copy of the release. as valid as the original, and that this nerwise noted above.			
Signature:							
D 1							





Authorization to Disclose Protected Health Information

I hereby authorize:		To release to: (Specific person/class of persons/organization) Address			
(Specific person/class of persons/organization	on)				
Address					
City, State, Zip Pho	ne #	City, State, Zip	Phone #		
Information contained in the member file	of:				
Name of Member	Date of Birth	Member ID Number	Date(s) of Service		
For the specific purpose of: (If you do not	wish to state a purpos	se please state "At the request of	of the Individual.")		
Requested (check all that apply):					
☐ Claim(s) Data (Member Profile) ☐ Medication List ☐ History and Physical ☐ Most Recent History and Physical ☐ Operative Report ☐ Psychiatric & Psychological Information I understand that by signing this form I give perrecipient and agree to hold both the releaser and to information in my health record may include information. I understand that the revoke this authorization. I understand that the revoke right to contest a claim under my policy. Unless of condition: If I fail to spect understand that my authorized representative or shall be as valid as the original. I understand that my authorized representative or shall be as valid as the original. I understand that authorizing the disclosure of this this form in order to ensure treatment. I understand 164.524. I understand that my health plan may condition may requested by the health plan prior to my enrollmed determinations relating to me or its underwriting psychotherapy notes. Complete only if Sentara rethis disclosure I understand that any disclosure of information can be protected by confidentiality laws. If I have que 757-857-8494.	nission to release the sphe recipient harmless formation relating to sext.). It may also include in norization at any time. It at the revocation will not apply to notherwise revoked, this ify an expiration date, or I may receive a copy of that I may inspect or any enrollment in the heart if the authorization is or risk rating determination quested the disclosure of the recipient of the potential of the potential of the recipient in the heart if the authorization is or risk rating determination in the heart if the potential determination is or risk rating determination in the heart in the potential determination is or risk rating determination in the heart in the potential determination is or risk rating determination in the heart in the potential determination is or risk rating determination in the heart in the potential determination is or risk rating determination in the heart in the potential determination is or risk rating determination in the heart in the potential determination in the heart in the heart in the potential determination in the heart	Immary In Record In Most R In Progres In Other In Record In Progres In Other In Record In Progres In Record In Rec	ete Medical Record ecent Discharge Summary es / Clinical Record gnated above to the designated on. I understand that the i immunodeficiency syndrome ental health services, and ractices for instructions as to ready been released in response ew provides my insurer with the ellowing date, event, or on will expire in six (6) months. raphic copy of this authorization authorization. I need not sign r disclosed, as provided in CFR on provision of an authorization bility or enrollment for use or disclosure of will not receive remuneration for e and the information may not		
Signature of Patient or Legal Representative		Date			
If signed by Legal Representative, relationsh	nin to Member	Signature of Witness	<u></u>		