



Member Grievances

If you have a grievance or problem with a provider or a concern about the quality of care or services you have received, please call Member Services. We will do our best to answer your questions or help you solve your problem.

Filing a grievance will not affect your health care services. We want to know your concerns so we can improve our services to you. You can call Member Services for help with problems with authorizations, covered services, payment for services or quality of services. If you call to report a grievance that is not about quality of care, we will try to solve it right away and tell you the result right then if we can. If we cannot solve your problem right away, we will solve it within two days. If we need to get more information, we may take up to seven days to solve the problem.

If you have a quality of care grievance we will send it to our Quality Management Department for review.

Member Appeals

Actions

An action by Mercy Healthcare Group (MHG) means:

- The denial or limited authorization of a service you or your doctor have asked for
- The reduction, suspension or ending of an existing service
- The denial of payment for a service, either all or part
- Failure to provide services in a timely manner
- Failure to act within certain timeframes for grievances and appeals
- Denial of a rural member's request to get services out of the network when MHG is the only health plan in the area

Denials, Reduction, Suspension or Termination of Services and Request for Appeal

Denial of Services	Reduction, Suspension or Termination of Services
<p>Member requests for many services must be reviewed and approved first by Mercy Healthcare Group doctors. If MHG decides the services cannot be approved, we will write to you within fourteen working days and tell you why. We will also let your doctor know. You can discuss it with your doctor.</p>	<p>If a reduction, suspension or ending of your services happens, we will write to you at least 10 days before the change to let you know.</p>

Notice of Action

If Mercy Healthcare Group decides that the requested service cannot be approved, or if a service is reduced, suspended or ended, you will get a "Notice of Action" which will tell you:

- What action was taken and the reason for it
- Your right to file an appeal and how to do it
- Your right to ask for a fair hearing with AHCCCS and how to do it
- Your right to ask for an expedited resolution and how to do it
- Your right to ask that your benefits be continued during your appeal, how to do it and when you may have to pay the costs for the services

Appeals Process

If you disagree with Mercy Healthcare Group’s action about your health care services, you may file an appeal either in writing or over the phone. If you need an interpreter, one will be provided.

You, your representative or a provider acting with your written permission may file an appeal within 60 days from the date of your denial, suspension, reduction or termination letter (Notice of Action). To file an appeal, you must call or send a letter to:

Mercy Healthcare Group
 Appeals Department
 4350 E. Cotton Center Blvd., Bldg. D
 Phoenix, AZ 85040
 (602) 798-2800 or (800) 780-2300

When Mercy Healthcare Group gets your appeal, we will send you a letter within five days telling you that we have your appeal and how you may give us more information either in person or in writing. If you wish services to continue while your appeal is reviewed, you must file your appeal no later than **10 days** from the date of Mercy Healthcare Group's Notice of Action letter to you.

The Appeals Department will review your appeal and send a decision in writing to you within 30 days. The letter will tell you what Mercy Healthcare Group's decision was and the reason for the decision. If Mercy Healthcare Group denies your appeal, you may then request a fair hearing with AHCCCS by following the steps in our decision letter to you.

If you request a hearing, you will receive information from AHCCCS about what to do. Mercy Healthcare Group will forward its file and documentation to the AHCCCS Office of Legal Assistance.

If after the hearing AHCCCS decides that Mercy Healthcare Group's decision was correct, you may be responsible for payment of the services you received while your appeal was being reviewed. If AHCCCS decides that Mercy Healthcare Group's decision was incorrect, Mercy Healthcare Group will authorize and provide the services promptly.

Request for Expedited Resolution

You may file an appeal within 60 days from the date of your notification letter and request that Mercy Healthcare Group review its action within three days (expedited resolution). You may request an expedited resolution by writing or calling MHG at the address and number listed under "Appeals Process." You may request that your services be continued during your appeal if you file your request within 10 days from the date of the letter from Mercy Healthcare Group.

If Mercy Healthcare Group decides that it is not medically necessary to issue a decision in three days, your appeal will be resolved within the standard 30 days. If Mercy Healthcare Group denies your request for services, you may request a fair hearing with AHCCCS by following the steps in your decision letter.

If after the hearing AHCCCS decides that Mercy Healthcare Group's decision was correct, you may be responsible for payment of the services you received while your appeal was being reviewed.