Provider Communication

WELL SENSE HEALTH PLAN

DATE: July 17, 2020

TO: All Well Sense Health Plan Providers

FROM: Well Sense Health Plan

SUBJECT: **Provider Administrative Appeals & Member Appeals**

Provider Administrative Appeals & Member Appeals

Provider Administrative Claims Appeals

Provider Administrative Claims Appeals are for services that have already been rendered to a member and differ significantly from the Member Appeals process (see below). Providers must submit administrative claims appeals to the appropriate address, timely and with all required documentation described in the Provider Administrative Claims Policy. Incomplete requests will be dismissed. Providers should refer to their BMC HealthNet Plan contracts for specific timely filing timeframes and call the Provider Service department to with any questions pertaining to filing an appeal. Information on Provider Administrative Claims Appeals can be found in Chapter 9 of the Provider Manual.

Member Appeals

Member Appeals are generally for services that have not yet occurred or services that have occurred but are listed in the member's benefit document as non-covered. Providers may file Member Appeals on behalf of members. A BMC HealthNet Plan initial denial letter will specify if a request is eligible for a Member Appeal. This information, including how to file a Member Appeal, where to direct a Member Appeal and the timeframes allowed for filing, can be found after the denial reason(s) in the denial letter. It is imperative that Member and Provider Appeals are directed to the appropriate departments.. For more information, please see Chapter 10 of the Provider Manual.

General Information

For all important contact information, services managed by our partners, prior authorization information, and claims, appeals and authorizations information, read our Quick Reference Guide.