Grievance and Appeal Request Form Information

A grievance or appeal is a way for you to provide TriHealth Benefit Solutions a concern about your experience. We strive to deliver the best service to all of our members. TBS utilizes the following two types of formal processes:

Grievance: A grievance is an expression of dissatisfaction about any matter other than an adverse benefit determination. This may include any member of the TBS Team, healthcare quality, any aspect of services such as quality, accessibility, behavior or performance.
*Patient Experience *Quality *Inaccurate or Incomplete Diagnosis *Billing Practices *Unexpected Result from Services *Rendered Accessibility

Appeal: An appeal is a request to change a previous decision, or adverse benefit determination.
*Precertification (Authorization) Denial *Claim Reimbursement Denial *Benefit Denial *Medical Necessity Denial *Maximum Reimbursable Amount *Non-Covered Service Denial *Non-Participating Provider *Readmissions

The Grievance and Appeal process allows full opportunity to report any concern or dissatisfaction. After TriHealth Benefit Solutions receives the information, we will review the concerns to determine if the investigation will be completed internally or forwarded to a different department based on the details provided. Claim Appeals must be received within **180 days** following receipt of notification of an initial Adverse Benefit Determination. The Plan will not accept appeals filed after a 180 day timeframe.

TriHealth Benefit Solutions will conduct a timely and impartial investigation and provide a written response upon completion of our review. Please provide all details related to the concern. A response will be provided no later than 30 days from receipt.

TriHealth Benefit Solutions will not retaliate in any way and submitting a grievance or appeal will not influence your treatment, payment, enrollment or eligibility for benefits.

To report any concern or dissatisfaction members or a member's authorized representative can submit a grievance or appeal in the following ways:

- Contacting TriHealth Benefit Solutions
  Customer Service Department
  1-833-999-4827

- Completing and submitting the Grievance and Appeal Form to TriHealth Benefit Solutions by:

  - Mail: TriHealth Benefit Solutions
    Attn: Grievance and Appeal Department
    PO Box 211775
    Eagan, MN 55121

  - Email: tbsgrievanceappeals@trihealth.com

TriHealth Benefit Solutions

Grievance and Appeal Request Form

I. MEMBER INFORMATION (to be completed by member)

Member Last Name	Member First Name, Middle Initial	Date of Birth (MM/DD/YYYY)
Group Number	Member ID Number	Daytime Phone Number
Street Address	City, State, Zip	Alternative Phone Number

II. LEGAL REPRESENTATION (Only Complete if applicable)

Are you filing this complaint for the member? ☐ Yes ☐ No	Name (First, Last)	Relationship
Street Address	City, State, Zip	Daytime Phone Number

Please Note: If you are a legal representative for the member, you must attach copies of your authorization as required by state law to represent the member – for example, healthcare power of attorney, healthcare surrogate, living will, or guardianship papers.

III. PROVIDER INFORMATION

Provider Type (Check one if applicable):

☐ Professional
☐ Facility

Provider Last Name	Provider First Name	Facility/Group Name
Provider Street Address		Provider Phone Number
City	State	Zip

IV. REQUEST DETAIL

List Date of Service(s) (MM/DD/YYYY) for request of review:
From ____/____/____ To ____/____/____

Relationship to patient (check one):
☐ Self
☐ Provider filing grievance or appeal for a member (written authorization from the member is required)
☐ Authorized Representative or Legal Guardian

Indicate the reason(s) for the Grievance and Appeal Form request (check all that apply):

GRIEVANCE

☐ Patient Experience ☐ Quality ☐ Inaccurate or Incomplete Diagnosis ☐ Billing Practices ☐ Unexpected Result from Services Rendered ☐ Accessibility ☐ Other (please describe) _____

APPEAL

☐ Precertification (Authorization) Denial ☐ Claim Reimbursement Denial ☐ Benefit Denial ☐ Medical Necessity Denial ☐ Maximum Reimbursable Amount ☐ Non-Covered Service Denial ☐ Non-Participating Provider ☐ Readmissions ☐ Second Level Review ☐ External Review ☐ Other (please describe) _____

TriHealth Benefit Solutions

Grievance and Appeal Request Form Detail

Describe in detail your request for the grievance or appeal indicated above. Please be specific as possible. (Attach additional pages as needed)

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V. ACCOMMODATIONS

Do you need special accommodations for TriHealth Benefit Solutions to communicate with you about this complaint? (Check all that apply)

☐ Braille ☐ Large Print ☐ Electronic mail ☐ TDD ☐ Sign Language (specify language) _____

☐ Foreign language interpreter (specify language) _____

V. SIGNATURE Please sign and date this complaint.

MEMBER SIGNATURE	AUTHORIZED REPRESENTATIVE, LEGAL REPRESENTATIVE OR PROVIDER SIGNATURE (if applicable)	DATE

VI. Please send the completed Grievance and Appeal Form with supporting documentation in one of the following ways:

- Mail: TriHealth Benefit Solutions
  Attn: Grievance and Appeal Department
  PO Box 211775
  Eagan, MN 55121

- Email: tbsgrievanceappeals@trihealth.com

TriHealth Benefit Solutions
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Cincinnati, OH 45212
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