Your Guide to Disputing a Claim

Disagree with the outcome of a claim? Here's everything you need to know about disputing a pre-service or post-service claim.

BlueCross BlueShield Federal Employee Program®

Pre-Service Claims

Who this information is for:

- All Federal Employees and their families
- United States Postal Service employees and their families

If you have a pre-service claim and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review by following the procedures listed below. Note that these procedures apply to requests for reconsideration of concurrent care claims as well. (If you have already received the service, supply, or treatment, then your claim is a post-service claim and you must follow the entire disputed claims process detailed in Section 8 of your benefit plan brochure, also detailed on page 3 of this fact sheet).

To reconsider a non-urgent care claim

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of your benefit plan brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to:

- Precertify your inpatient admission or, if applicable, approve your request for prior approval for the service, drug, or supply; or
- Write to you and maintain our denial; or
- Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

To reconsider an urgent care claim

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of your benefit plan brochure.

Unless we request additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will expedite the review process, which allows verbal or written requests for appeals and the exchange of information by phone, electronic mail, facsimile, or other expeditious methods.

If you still disagree with our decision on your pre-service claim, you may file an appeal with OPM

After we reconsider your pre-service claim, if you do not agree with our decision, you may request that OPM review it by following Step 3 of the disputed claims process outlined in Section 8 of your benefit plan brochure.

Attention Medicare Prescription Drug Program Participants

Note: If you are enrolled in our Medicare PDP EGWP and do not agree with our benefit coverage decision, you have the right to appeal. Postal Service Health Benefit Program Participants, you can see Section 8(a) below for information about the PDP EGWP appeal process.

When a claim is denied in whole or in part, you may appeal the denial. To learn more about your rights and how to file a dispute, please follow the instructions found at **www.fepblue.org/medicarerx/resources.**

Request for Reconsideration of Medicare Prescription Drug Denial

Because your Medicare drug plan has upheld its initial decision to deny coverage of, or payment for, a prescription drug you requested, or upheld its decision regarding an at-risk determination made under its drug management program, you have the right to ask for an independent review of the plan's decision. You need the form to request an independent review of your drug plan's decision. You have 60 days from the date of the plan's Redetermination Notice to ask for an independent review. Please complete the form and mail or fax it as instructed. They will review your request and provide you with a decision and further instructions on next steps if you still disagree with the outcome. For additional assistance, please call us at 888-338-7737, TTY: 711.

Post-Service Claims

Who this information is for:

- All Federal Employees and their families
- United States Postal Service employees and their families

If you have a post-service claim where you have already received the service, supply, or treatment, you must follow the procedures listed below. (If you are disputing a decision regarding precertification of an inpatient admission or prior approval of other services, then your claim is a pre-service claim and you must follow the entire disputed claims process detailed in Section 3 of your benefit plan brochure, also detailed on page 1 of this fact sheet).

1. **Ask us in writing to reconsider our initial decision.**

You must:

- Write to us within 6 months from the date of our decision; and
- Send your request to us at the address shown on your explanation of benefits (EOB) form for the Local Plan that processed the claim (or, for Prescription drug benefits, our Retail Pharmacy Program, Mail Service Prescription Drug Program, or the Specialty Drug Pharmacy Program); and
- Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and
- Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.

We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in Step 3.

2. **In the case of a post-service claim, we have 30 days from the date we receive your request to respond.**

Our response may include the following:

- That you need to pay the claim; or
- That we maintain our denial; or
- We need more information from you or your provider.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. If you do not agree with our decision, you may ask OPM to review it.

You must write to OPM within:

- 90 days after the date of our letter upholding our initial decision; or
- 120 days after you first wrote to us – if we did not answer that request in some way within 30 days; or
- 120 days after we asked for additional information – if we did not send you a decision within 30 days after we received the additional information.

Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employees Insurance Operations, FEHB 1, 1900 E Street NW, Washington, DC 20415-3610.

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in the benefits brochure,
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim;
- Your daytime phone number and the best time to call; and
- Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly.

Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a healthcare professional with knowledge of your medical condition may act as your authorized representative without your express consent.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

4. **OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct.**

OPM will determine if we correctly applied the terms of our contract when we denied your claim or request for service. OPM will send you a final decision or notify you of the status of OPM's review within 60 days. There are no other administrative appeals.

If you do not agree with OPM's decision, your only recourse is to file a lawsuit. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies, or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claims decision. This information will become part of the court record.

You may not file a lawsuit until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Attention Federal Employees Health Benefits Program Participants

Note: If you have a serious or life-threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at the customer service phone number on the back of your Service Benefit Plan ID card. We will expedite our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's FEHB 1 at 202-606-0727 between 8 a.m. and 5 p.m. Eastern Time.

Please remember that we do not make decisions about Plan eligibility issues. For example, we do not determine whether you or a family member is covered under this Plan. You must raise eligibility issues with your agency personnel/payroll office if you are an employee, your retirement system if you are an annuitant, or the Office of Workers' Compensation Programs if you are receiving Workers' Compensation benefits.

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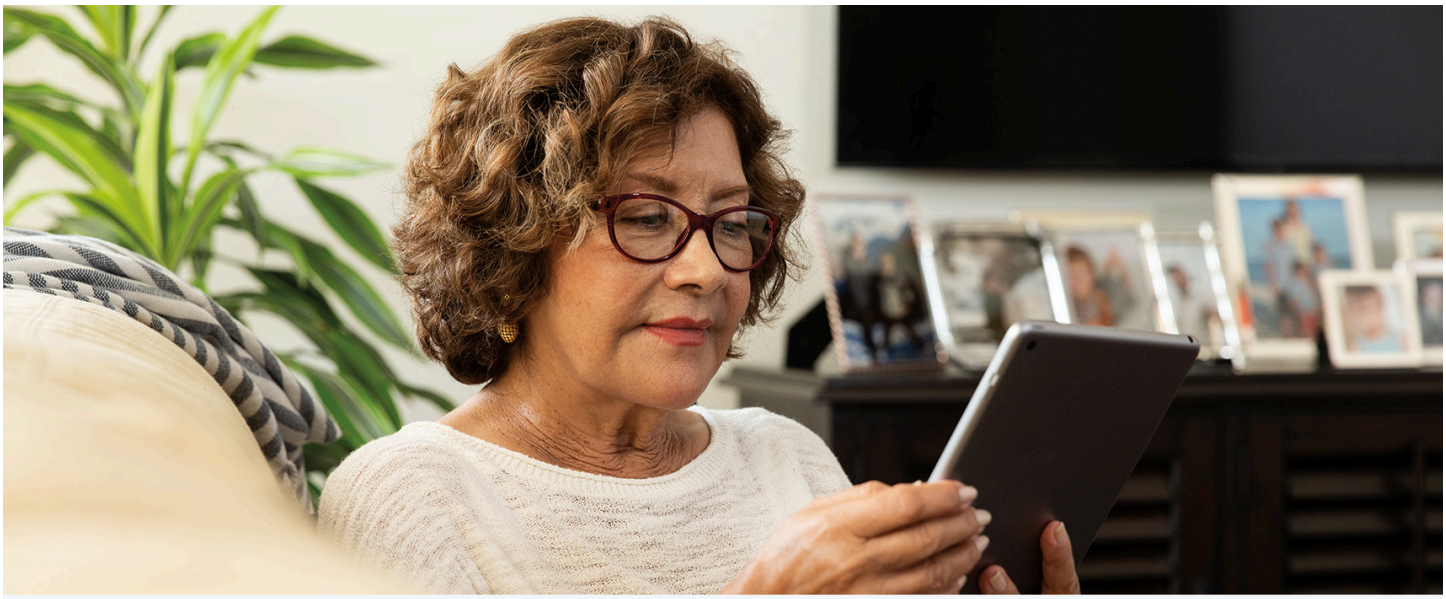

Visit **fepblue.org/brochures** to view or download the Blue Cross and Blue Shield Service Benefit Plan brochures for full details.