Know Your Appeal Rights

Your insurance company, **Anthem BCBS,** has hired a third party to authorize therapy benefits. This company is AIM Specialty Health. Many public and private health plans including Medicaid, Medicare Advantage, and individual and employer sponsored plans use utilization management companies to determine whether the care being provided to you is medically necessary *instead of what your physician and/or physical therapist recommend is medically necessary.*

What are we doing for you?

Our administrative and professional therapy staff are working tirelessly on your behalf to ensure medically necessary services are authorized. We provide all necessary documentation and communicate regularly with AIM Specialty Health and, if necessary, with your insurer. As your clinician, we will provide you with our professional clinical judgement regarding your care and support you in seeking appropriate coverage.

What does this mean for you?

AIM Specialty Health requires your therapist to fill out forms online to authorize all therapy treatment, except for your initial evaluation. In some cases, it may take AIM Specialty Health several days to respond to our request for therapy visits for you and your family. As a result, your treatment with us may be **delayed, modified, or denied**.

What will happen if your treatment is delayed, modified, or denied?

If our office receives notice that your treatment has been modified or denied, we will make every effort to appeal AIM Specialty Health's determination on your behalf. However, please be aware that we cannot guarantee that the denial will be overturned on appeal.

If you believe your medically necessary treatment has been delayed, denied, or inappropriately restricted and *we are unable to appeal on your behalf*, **<u>you</u>** have the right to request an appeal to resolve differences with your plan. You have the right to ask your plan to pay for therapy services you believe should be covered. If you decide to submit an appeal, make sure to keep a copy of everything you send to your plan as part of that appeal. At each level of appeal, you will receive a decision letter with instructions on how to move to the next level of appeal. If we can assist you in any way with filing an appeal, please let our staff know.

What can *you* do to advocate for yourself if you think your care has been delayed or necessary services impeded or denied?

If your appeal is unsuccessful and you would like to file a complaint you may be able to reach out to your HR Department or the Colorado Insurance Commissioner's Office:
Go to: www.colorado.gov/dora (Click on "I want to…." > Go to "File" > Go to "A Complaint")
Or call: 1-800-930-3745

While filing appeals and registering complaints isn't easy, it is the most effective way to ensure you and other beneficiaries have access to the medically necessary care you deserve.

It is your right to have your opinion heard.