



Important Information About Your Part C Appeal and Grievance Rights

What Is A Grievance?

Medicare defines a grievance as: Any complaint or dispute, other than one involving an organization determination, expressing dissatisfaction with the manner in which a Medicare health plan or delegated entity provides health care services, regardless of whether any remedial action can be taken. An enrollee, or their representative, may make the complaint or dispute either orally or in writing, to a Medicare health plan, provider, or facility. An expedited grievance may also include a complaint that a Medicare health plan refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration time frame. In addition, grievances may include complaints regarding the timeliness, appropriateness, access to and/or setting of a provided health service, procedure, or item. Grievance issues may also include complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Filing A Grievance With Our Plan

If you have a complaint, you or your representative may call Customer Service at the phone number listed at the end of this document. You may also send us your complaint in writing. We call this our grievance procedure. As an enrollee of Fresenius Health Partners (also referred to as “Plan”), if your complaint is received by telephone, Fresenius Health Partners, will address and resolve your complaint by telephone, especially if your complaint involves a possible misunderstanding or misinformation. If you request a written response to your phone complaint, or if your complaint is regarding a Quality of Care issue, we will respond in writing to you. If we receive your complaint in writing we will respond in writing. The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension or if we justify a need for additional information and the delay is in your best interest.

What If I Don’t Agree With A Decision?

You have the right to appeal. To exercise it, file your appeal in writing within 60 calendar days after the date of your Explanation of Benefits or Notice of Denial of Medical Coverage. You can file an appeal if the Plan will not pay for, does not allow, or stops a service that you think should be covered or provided. If you think your health could be seriously harmed by waiting for a decision about a service you have not yet received, ask the Plan for an expedited (fast) appeal. The Plan must answer you within 72 hours. We



can give you more time if there are special circumstances or a good reason for missing the deadline.

If you are getting Medicare services from a hospital, skilled nursing facility, home health agency, comprehensive outpatient rehabilitation facility, or hospice, and you think your Medicare-covered services are ending too soon, you have the right to a fast appeal (also called an “expedited appeal”). Your provider will give you a notice at least 2 days before your services end that will tell you how to ask for a fast appeal. If you don’t get this notice, ask your provider for it. With a fast appeal, an independent reviewer, called a Quality Improvement Organization (QIO), will decide if your services should continue. You may ask your doctor for any information that may help your case if you decide to request a fast appeal. You may call your local QIO to request a fast appeal no later than noon on the day before your notice says coverage will end. The number for the QIO in your state should be on your notice. You can also call the Plan’s Customer Service to obtain the phone number for the QIO in your state. If you miss the deadline, you still have appeal rights through the Plan’s expedited appeals process.

Who May File An Appeal?

You or your authorized representative may file an appeal. If you want someone to act as your representative, you and your authorized representative must sign, date and send us a statement naming that person to act on your behalf. You can visit: <http://www.cms.gov/cmsforms/downloads/cms1696.pdf> to learn how to name your authorized representative or call Customer Service at the number provided at the end of this document.

How Do I File An Appeal?

You or your authorized representative should mail or deliver your written and signed appeal to:

Fresenius Health Partners
Attn: Appeals & Grievance Department
7100 Commerce Way, Suite 285
Brentwood, TN 37027

FAX: 1-615-782-7971

We must give you a decision no later than 30 calendar days after we receive your appeal.



Fresenius Health Partners
PPO SNP
Accountable Kidney Care

What Do I Include With My Appeal?

You should include: your name, address, Member ID number, signature, reasons for appealing, and details such as date(s) of service and provider names or claim/reference numbers, any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should pay for the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

What Happens Next?

If you appeal, we will send you an acknowledgement letter letting you know how long we have to resolve your appeal. We will research and review your issue(s). If we decide our first decision to deny coverage or payment for services was correct, the Plan will automatically send your appeal to the Independent Review Entity contracted by Medicare for a new and impartial review. This is known as the second level appeal. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens. If you have any questions or concerns about the appeal and grievance processes, or wish to inquire on the status of your appeal or grievance, please call Customer Service at the number below for assistance. You may also contact Customer Service to obtain an aggregate (total) number of grievances, appeals, and exceptions filed with the plan.

Calls to these numbers are free:

Fresenius Health Partners

1-866-307-3625, TTY: 1-877-736-2535

8 a.m. – 8 p.m., seven days a week in your local time zone

A Coordinated Care plan with a Medicare Advantage contract and a Medicare-approved Part D sponsor.