



Member Grievance - First Level Process Tables

TABLE 21-6, FIRST LEVEL MEMBER GRIEVANCE - EXPEDITED

COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S):	WHAT/HOW/WHERE TO FILE INSTRUCTIONS:	TIME FRAMES:			ADDITIONAL RIGHTS:
		Initial Member Filing:	EmblemHealth Acknowledges Receipt:	EmblemHealth Determination Notification:	
HIP Commercial, HIP Child Health Plus	<p>Unless otherwise directed in the denial letter, sign in to: emblemhealth.com and use My Messages under username drop-down.</p> <p>Write to: EmblemHealth Grievance and Appeal Dept P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: 800-447-8255 (TTY: 711).</p>	<p>180 calendar days from receipt of written adverse determination.</p>	N/A	<p>No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance.</p> <p>Verbally at time of determination.</p> <p>Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.</p>	<p>May file a second level grievance.</p> <p>Additional complaints may be filed with the NYS DOH at any time by calling 800-206-8125.</p>
	<p>Unless otherwise directed in the denial letter, sign in to: emblemhealth.com and use My Messages under username drop-down.</p> <p>Write to:</p>	<p>180 calendar days from receipt</p>		<p>No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance.</p>	<p>May file a second level grievance.</p>

GHI HMO	<p>GHI HMO Appeals and Complaints Dept P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: <u>877-244-4466</u> (TTY: <u>711</u>)</p> <p>Fax to: <u>845-340-3435</u></p>	days from receipt of written adverse determination.	N/A	<p>Verbally at time of determination.</p> <p>Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.</p>	Additional complaints may be filed with the NYS DOH at any time by calling <u>800-206-8125</u> .
EmblemHealth EPO/PPO	<p>Unless otherwise directed in the denial letter, sign in to: <u>emblemhealth.com</u> and use My Messages under username drop-down.</p> <p>Write to:</p> <p>EmblemHealth P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: <u>212-501-4444</u> (TTY: <u>711</u>).</p>	180 calendar days from receipt of written adverse determination.	N/A	<p>No later than 48 hours from receipt of all necessary information but not to exceed 72 hours from receipt of the grievance.</p> <p>Verbally at time of determination.</p> <p>Written notice provided no later than 48 hours from receipt of all necessary information or 72 hours from receipt of the grievance.</p>	May file a second level grievance.

TABLE 21-7, FIRST LEVEL MEMBER GRIEVANCE - STANDARD

FOR COMMERCIAL AND CHILD HEALTH PLUS PLANS

BENEFIT PLAN(S):	<p>WHAT/HOW/WHERE TO FILE INSTRUCTIONS:</p> <p>Unless otherwise directed in the denial letter, sign in to <u>emblemhealth.com</u></p>	TIME FRAMES:			ADDITIONAL RIGHTS:
		Initial Member Filing:	EmblemHealth Acknowledges Receipt:	EmblemHealth Determination Notification:	

<p>HIP Commercial, HIP Child Health Plus</p>	<p>to: emblemhealth.com and use My Messages under username drop-down.</p> <p>Write to:</p> <p>EmblemHealth Grievance and Appeal Dept P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: 800-447-8255 (TTY: 711).</p>	<p>180 calendar days from receipt of written adverse determination.</p>	<p>Pre-Service: Acknowledgement is not required if the response is sent by the 15th calendar day of receipt.</p> <p>Post-Service: 15 calendar days from receipt of the grievance.</p>	<p>Pre-Service: 15 calendar days from receipt of the grievance.</p> <p>Post-Service: 30 calendar days from receipt of grievance.</p>	<p>May file a second level grievance.</p> <p>Additional complaints may be filed with the NYS DOH at any time by calling 800-206-8125.</p>
<p>GHI HMO</p>	<p>Unless otherwise directed in the denial letter, sign in to: emblemhealth.com and use My Messages under username drop-down.</p> <p>Write to:</p> <p>GHI HMO Appeals and Complaints Dept P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: 877-244-4466 (TTY: 711).</p> <p>Fax to: 845-340-3435</p>	<p>180 calendar days from receipt of written adverse determination.</p>	<p>*15 business days from receipt of the grievance (post-service).</p> <p>*Acknowledgement is not required if responded to within 15 calendar days</p>	<p>Pre-Service: 15 calendar days from receipt of the grievance.</p> <p>Post-Service: 30 calendar days from receipt of grievance.</p>	<p>May file a second level grievance</p> <p>Additional complaints may be filed with the NYS DOH at any time by calling 800-206-8125.</p>
<p>EmblemHealth EPO/PPO</p>	<p>Unless otherwise directed in the denial letter, sign in to: emblemhealth.com and use My Messages under username drop-down.</p> <p>Write to:</p> <p>EmblemHealth P.O. Box 2844 New York, NY 10116-2844</p>	<p>180 calendar days from receipt of written adverse determination.</p>	<p>*15 business days from receipt of the grievance (post-service).</p> <p>*Acknowledgement is not required if responded to within 15 calendar days.</p>	<p>Pre-Service: 15 calendar days from receipt of the grievance.</p> <p>Post-Service: 30 calendar days from receipt of grievance.</p>	<p>May file a second level grievance.</p>

	Telephone: <u>212-501-4444</u> (TTY: <u>711</u>)				
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