




Table 21-11, Appeal - Standard

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COMMERCIAL AND CHILD HEALTH PLUS PLANS					
BENEFIT PLAN(S):	WHAT/HOW/ WHERE TO FILE INSTRUCTIONS:	TIME FRAMES:			ADDITIONAL RIGHTS:
		Initial Member/Provider * Filing:	EmblemHealth Acknowledges Receipt:	EmblemHealth Determination Notification:	
HIP Commercial, HIP Child Health Plus	<p>Unless otherwise directed in the denial letter, write to:</p> <p>EmblemHealth Grievance and Appeal Dept P.O. Box 2844 New York, NY 10116-2844 Telephone: 888-447-6855</p>	<p>Member: 180 calendar days from receipt of written adverse determination.</p> <p>Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination.</p> <p>For Payment: 45 calendar days from receipt of written adverse determination.</p>	15 calendar days from receipt of the appeal	<p>HMO: 30 calendar days from receipt for pre-service requests.</p> <p>PPO/EPO: 30 calendar days for all requests.</p> <p>Both member and provider notified within two business days of determination but not to exceed determination timeframe.</p>	<p>External Appeal</p> <p>Additional complaints may be filed with the NYS DOH at any time by calling 800-206-8125.</p>
GHI HMO	<p>EmblemHealth Grievance and Appeal Dept P.O. Box 2844 New York, NY 10116-2844 Telephone: 877-244-4466. TDD: 877-208-7920. Fax to:</p>	<p>Member: 180 calendar days from receipt of written adverse determination.</p> <p>Provider: Pre-Service on behalf of member: 180 calendar days from receipt of written adverse determination.</p> <p>For Payment: 45</p>	15 calendar days from receipt of the appeal.	<p>30 calendar days from receipt for pre-service requests.</p> <p>Both member and provider notified within two business days of determination but not to exceed</p>	<p>External Appeal</p> <p>Additional complaints may be filed with the NYS DOH at any time by calling 800-206-8125.</p>

	845-340-3435.	calendar days from receipt of written adverse determination..		determination timeframe.	
EmblemHealth PPO/EPO	<p>Unless otherwise directed in the denial letter, write to:</p> <p>EmblemHealth Supervisor of Appeals P.O. Box 2844 New York, NY 10116-2844</p> <p>Telephone: <u>888-906-7668.</u> Fax to: 212-287-2754.</p>	<p>Member: 180 calendar days from receipt of written adverse determination.</p> <p>Provider: Pre- Service on behalf of member: 180 calendar days from receipt of written adverse determination.</p> <p>For Payment: 45 calendar days from receipt of written adverse determination.</p>	15 calendar days from receipt of appeal	<p>30 calendar days</p> <p>Both member and provider notified within two business days of determination but not to exceed determination timeframe.</p>	External appeal

*Contracted provider time frames in provider agreements will supersede time frames in this manual.