

Appeal Process Options

You have the right to appeal a Health Tradition decision. You must appeal this decision within forty-five (45) days. We cannot treat you differently than other members because you file a complaint. Your health care benefits will not be affected.

You can do this in several ways.

1. You may ask us to review our decision. You can write or call:

Health Tradition Health Plan
P.O. Box 188
La Crosse, WI 54602-0188
Phone: 608-781-9692
or
Toll-free at 1-888-459-3020

2. You may contact the State of Wisconsin to review our decision. You can write or call:

BadgerCare Plus Managed Care Ombuds
PO Box 6470
Madison, WI 53716
Phone: 1-800-760-0001

3. If you need help in filing an appeal or want to know more about your rights, you can call:

BadgerCare Plus Managed Care Ombuds 1-800-760-0001
or
HMO Enrollment Specialist 1-800-291-2002

4. You can contact the Division of Hearing and Appeals. You must ask for a fair hearing within 45 days of this letter. The hearing will be held in the county where you live. To ask for a fair hearing, send a written request to:

Department of Administration
Division of Hearing and Appeals
PO Box 7875
Madison, WI 54707-7875

Note: If you need special arrangements for hearing disability or for English translation, call 608-266-3096 (voice) or 608-264-9853 (hearing impaired)

Health Tradition Health Plan
PO Box 188
La Crosse, WI 54602-0188
1-888-459-3020 (Toll-free) or 608-781-9692

Member Appeal Form
BadgerCare Plus

Today's Date: _____

Name of person appealing: _____ Relationship: _____

Phone: (Day) _____ (Evening) _____

Street Address: _____

City, State, Zip: _____

Patient's Name: _____

Patient's Member I.D. _____ Date of Birth _____

Summary of Complaint:

- 1) Date problem happened: _____
- 2) Problem (describe what happened; please give names of individuals; attach additional pages if necessary): _____

- 3) How would you like to see this problem fixed? _____

- 4) Has anyone tried to help you with this problem already? Yes _____ No _____
If yes, who? (please give name & phone number) _____

- 5) I want to appear before the Grievance Committee. yes no

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Member Appeal Form

BadgerCare
(Continued)

- 6) Do you want to submit written questions to the person or persons responsible for making the decision? yes no
Please list questions below. We will have the responses for you during the Grievance Committee meeting.

- 7) Do you or your representative wish to attend the meeting in person? yes no

If you want an authorized representative to act on your behalf in this appeal, we require a signed Authorized Representative Form or proof of Power of Attorney. Medical Information will not be released to your representative in the course of the appeal unless a Medical Release of Information Form is also signed. Please contact the Plan at the address or phone numbers above to request assistance with this process. Under certain extenuating circumstances a signature is not possible. Contact us for more information so that we can assist you in meeting your needs.

- 8) Would you prefer to attend via telephone conference call? yes no
- 9) Do you need any special arrangements? yes no

Please describe any special needs:

Signature _____

Health Tradition Appeals Process

Your grievance will be reviewed as soon as Health Tradition receives this completed form. We may need to research the issues to resolve the problem. The Grievance Committee will attempt to resolve your complaint within 15 days for those situations where the service has not yet been provided and 30 days for those situations where the service has already occurred. If we cannot resolve your complaint in the 15- or 30-day time frame, we will notify you in writing on or before day 15 (before service) or day 30 (after service) with the reason for the delay. If the grievance cannot be resolved in the way you would like, the second appeals process can be initiated.

Please refer to your BadgerCare Plus Member Handbook for the appeals process. You may contact us through the local or toll-free number listed above if you have any questions.

Translation Information

English – For help to translate or understand this, please call 1-800-545-8499.

Spanish – Si necesita ayuda para traducir o entender este texto, por favor llame al teléfono 1-800-545-8499.

Russian – Если вам не всё понятно в этом документе, позвоните по телефону 1-800-545-8499.

Hmong – Yog xav tau kev pab txhais cov ntaub ntawv no kom koj totaub, hu rau 1-800-545-8499.

Laotian – ເພື່ອຊ່ວຍໃນການແປ ຫລືເຂົ້າໃຈເນື້ອຫາໃນນີ້, ກະລຸນາໂທຣະສັບຫາ 1-800-545-8499.

(TTY) 1-888-459-3020