9 Payment Appeals and Grievances

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Grievances ............... 180
Appeals

Participating Provider Appeals

Oxford’s administrative procedures require facility, physician or other healthcare provider participating in Oxford’s network to file an internal appeal before proceeding to arbitration under their contract. If as a participating provider you want to dispute a claim payment determination or a medical necessity determination, your dispute is eligible for an individual one-step internal appeal process. You must file your appeal request within 180 days of the date noted on Oxford’s initial determination notification. On appeal, you must include all relevant clinical documentation that you wish to submit for consideration including the entire medical record related to the service. If the appeal is for an Oxford Medicare Advantage™ Member and the initial denial may result in Member liability for services (i.e., not a covered benefit, benefit exhausted, etc.), the Oxford Medicare Advantage Member appeals process must be used.

See Oxford Medicare Advantage Appeals in this section.

• **Decision maker** — For decisions involving medical judgment, the appeal will be reviewed and decided by a different peer reviewer than the reviewer who made the initial determination; for decisions involving payment disputes, the appeal will be reviewed and decided by a different decision maker than the decision maker who made the initial determination.

• **Untimely appeals** — If you submit an appeal after the appeal time frame has expired, Oxford will uphold the denial.

• **Pre-appeal claims review** — Before requesting an appeal, if you need further clarification of a payment determination, you may ask an Oxford Service Associate, verbally or in writing, for a review of the claims payment issue; the Service Associate will make every effort to explain Oxford’s actions; if you or the Member is found to be entitled to additional payment, Oxford will reprocess the claim and remit the additional payment.

To request the review of a claim, please call Oxford’s Provider Services Department to speak to a Service Associate at 1-800-666-1353.

Please note: A participating provider must follow the Oxford Medicare Advantage Member appeal process for all Oxford Medicare Advantage Members where the Member may be liable for the service.

Provider Appeals — Internal Administrative Appeals Process

Mandatory Internal Appeals Process under Your Contract for Medical Necessity Determinations

If as a participating provider you would like to dispute a medical necessity determination regarding services requested for an Oxford Member, you may mail a written request, with relevant supporting clinical documentation that shows why the denial of services should be reversed, to:

Oxford | Important Address

Clinical Appeals Department
Oxford Health Plans
P.O. Box 7078
Bridgeport, CT 06601-7078

If necessary clinical documentation is not supplied, Oxford’s Clinical Appeals Department will request such information.

Once the review is complete, Oxford will send written correspondence notifying you of Oxford’s decision. The Clinical Appeals Department will make a reasonable effort to render a decision within 120 days of receiving the appeal and supporting documentation. The decision of the Clinical Appeals Department is Oxford’s final position on the matter and is subject to the Post-Appeal Dispute Resolution Process explained in this section.

Please note: There is a separate internal and external claims payment appeal process for New Jersey participating providers who treat a New Jersey commercial Member.

Additional Requirements for Facilities

• Any requests for reconsideration through the Day of Service Program must be made prior to requesting an appeal.
• The entire medical record related to the denied service must accompany the appeal letter; if the medical records are not submitted, the denial will be upheld for lack of information unless the information already submitted supports a reversal of the decision; under such circumstances, the facility is prohibited from balance billing the Member.

• The Clinical Appeals Department will make all reasonable efforts to render a decision within 120 days of receiving the medical records.

Mandatory Internal Appeals Process Under Your Contract for Claims Payment Disputes

If you would like to dispute the payment of a claim that does not involve a medical necessity decision, you should appeal the claim by submitting a written request for appeal to:

Correspondence Unit
Oxford Health Plans
P.O. Box 7081
Bridgeport, CT 06601-7081

To be processed, an appeal* must include the reasons you believe that the claim should not have been denied (or the reasons additional reimbursement should be made), the Member's name and Oxford ID number and a copy of the remittance advice for the claim (or the claim number) in question along with any documentation (clinical or otherwise) that you believe supports reversal of Oxford's claim payment determination. The Correspondence Department will make all reasonable efforts to render a decision within 120 days of receiving the appeal and supporting documentation.

* A participating provider must follow the Oxford Medicare Advantage Member appeal process for all Oxford Medicare Advantage Members where the Member may be liable for services.

Provider Appeals — Post-Appeal Dispute Resolution Process for Medical Necessity and Claim Payment Determinations

If you have completed the internal appeals process and are not satisfied with the results of that internal appeal, under your contract with Oxford, you have a right to arbitrate your dispute with Oxford. Please consult your contract to determine the appropriate arbitration authority. Most such contracts provide for arbitration before the American Arbitration Association (AAA).

The costs of arbitration are borne equally by the participating provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration is binding on the participating provider and Oxford, pursuant to the provider agreement with Oxford. To commence arbitration, you must file a statement of claim with the appropriate arbitration authority. In most instances, the arbitration authority will require that you file a specified form with your statement of claims to begin the proceeding. The appropriate arbitration authority, such as the AAA, will have processes in place for the prompt resolution of cases involving time sensitivity.

The addresses and phone numbers for the AAA are as follows:

New York
American Arbitration Association
1633 Broadway, Floor 10
New York, NY 10019-6708
Phone: 1-212-484-3266
Fax: 1-212-307-4387

New Jersey
American Arbitration Association
220 Davidson Avenue
Somerset, NJ 08873-4159
Phone: 1-732-560-9560
Fax: 1-732-560-8850

Connecticut
American Arbitration Association
111 Founders Plaza, Floor 17
East Hartford, CT 06108-3248
Phone: 1-860-289-3993
Fax: 1-860-282-0459

Pennsylvania
American Arbitration Association
Northeast Case Management Center
950 Warren Avenue, 4th Floor
East Providence, RI 02914
Phone: 1-866-293-4053

Delaware
American Arbitration Association
Northeast Case Management Center
950 Warren Avenue, 4th Floor
East Providence, RI 02914
Phone: 1-866-293-4053

Additional information, rules and forms for arbitration before the AAA may be found on the AAA's web site at www.adr.org.
New Jersey State-regulated Appeal Process for Claim Payment Appeals Involving New Jersey Commercial Members

If as a New Jersey participating provider you are dissatisfied with and want to dispute a claims payment determination involving a New Jersey commercial Member, your dispute is eligible for an individual two-step appeal process. The First-Level Appeal must be made through Oxford’s internal appeal process and the Second-Level Appeal must be made through the external dispute resolution process.

New Jersey Mandated Internal Appeals Process for Claims Payment Disputes

An appeal of a claim determination filed by a New Jersey participating provider involving a New Jersey commercial Member shall be handled as follows:

- You should submit a written request for appeal concerning a claim payment dispute within 180 days of the date on Oxford’s initial determination notice to:

Oxford | IMPORTANT ADDRESS

Correspondence Unit
Oxford Health Plans
P.O. Box 7081
Bridgeport, CT 06601-7081

- To be processed, an appeal must include:
  - The reasons you believe that the claim should not have been denied (or the reasons additional reimbursement should be made)
  - Member’s name
  - Oxford identification number
  - Copy of the remittance advice or the claim number in question along with any documentation (clinical or otherwise) that supports reversal of Oxford’s claim payment determination
  - The review will be conducted by employees of the carrier, other than those who are responsible for claims payment on a day-to-day basis, without cost to the provider
  - The review will be conducted, and its results communicated to you in a written decision within 10 business days of receipt of all the materials necessary for such appeal
  - The written decision will include:
    - The names, titles and qualifying credentials of the persons participating in the review
    - A statement of the participating provider’s grievance
    - The decision along with an explanation of the contractual and/or medical basis for such decision
    - A description of the evidence or documentation that supports the decision
    - If adverse, a description of the method to challenge the determination
New Jersey Mandated External Dispute Resolution Appeal Process

If as a New Jersey participating provider you completed the internal appeals process and are not satisfied with the results of that internal appeal, you have the right, under your Oxford provider contract, to arbitrate your dispute with Oxford. Please consult your contract to determine the appropriate arbitration authority. Most such contracts provide for arbitration before the American Arbitration Association (AAA). The costs of arbitration are borne equally by the participating provider and Oxford, unless the arbitrator determines otherwise. The decision in such arbitration is binding on the participating provider and Oxford, pursuant to the provider agreement with Oxford. To commence arbitration, file a statement of claim with:

American Arbitration Association  
220 Davidson Avenue  
Somerset, NJ 08873-4159

The AAA has processes for prompt resolution of cases involving time sensitivity.

For information about arbitration before the AAA, please call the AAA at 1-732-560-9560.


This external appeals process only applies to services provided to Oxford commercial Members who have coverage by virtue of a HMO or insurance plan licensed in New York State. You may request an external appeal on your own behalf when Oxford has made a retrospective final adverse determination on the basis that the service or treatment is not medically necessary, or is considered experimental or investigational (or is an approved clinical trial) to treat the Member’s life-threatening or disabling condition (as defined by the New York State Social Security Law). A retrospective adverse determination is one where the initial medical necessity review is requested or initiated after the services have been rendered. This process does not apply to services where precertification or concurrent review is required.

Internal Medical Necessity Appeal

When denied retrospectively by Oxford’s Medical Management Department, a participating provider seeking to pursue an external appeal must first follow the First-Level Member Appeal Process with Oxford’s Clinical Appeals Department.

See Commercial Member Appeals in this section.

After the Clinical Appeals Department issues a retrospective final adverse determination, you will be eligible to file an external appeal. All requests for such internal retrospective appeals must be made within 60 days of receipt of the initial medical necessity or experimental/investigational determination. Retrospective appeals will be resolved within 60 days from the Clinical Appeals Department’s receipt of the information necessary to review the appeal.

External Appeal Process

If the Clinical Appeals Department upholds all or part of such an adverse determination, you may submit an external appeal. To do so, you must submit an external appeal form (including Member signature), a fee and the notice of the retrospective final adverse determination to the New York State Insurance Department within 45 days of receiving such a notice from a First-Level Appeal. Please send external appeal requests to:

New York State Insurance Department  
P.O. Box 7209  
Albany, NY 12224-0209  
Phone: 1-800-400-8882  
Fax: 1-800-332-2729

Commercial Member Appeals

Appeals may be filed by a Member or on a Member’s behalf by his or her representative or provider with the Member’s consent. If a third party files an appeal on a Member’s behalf, he or she must provide the Member’s name, the claim number, an authorization or ID number, and a signed written designation by the Member after the denial of services. This written designation permits the third party to appeal on the Member’s behalf.

For appeals of benefit determinations concerning urgent care, a health care provider with knowledge of the Member’s medical condition shall be permitted
to act as the Member’s authorized representative without written consent. A benefit determination concerning urgent care is defined as a determination which, if subject to the standard appeal time frames, could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, or in the opinion of a physician with knowledge of the Member’s condition, would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the determination.

**Medical Necessity Appeals**

**Standard Medical Necessity Appeals Process for Commercial Members**

If Members would like to file an appeal, they must hand-deliver or mail a written request within 180 days of receiving the initial denial determination notice to:

![Oxford Health Plans - Clinical Appeals Department - Commercial](bridgepoint-ct-06601-7078)

Members can fax their request to 1-203-459-3229

Verbal appeals can be submitted, however, Oxford encourages the use of written submissions to help ensure that all issues are identified.

**Expedited Medical Necessity Appeals Process**

Members have the right to request an expedited appeal and a provider may request an expedited appeal when requested to do so by the Member.

In order to request an expedited appeal, the Member or provider must:

- Request an expedited appeal verbally or in writing, and hand deliver, mail or fax the request (if in writing) to the address previously listed
- State specifically that the request is for an expedited appeal

Based on the following criteria, the Clinical Appeals Department will determine whether or not to grant an expedited request:

- If the time frame involved in reaching a decision through the standard appeal process would seriously jeopardize the Member’s life or health
- If the standard time frame involved in reaching a decision would jeopardize the Member’s ability to regain maximum function

If the Clinical Appeals Department determines that the request does not meet expedited criteria, then the Member will be notified verbally and in writing that the request will be handled through the standard appeal process. The appeal request will be reviewed within the standard time frame required by state regulations.

**Benefit Appeals**

Benefit denials issued by the Medical Management, Disease Management or Behavioral Health Department are handled by the Clinical Appeals Department.

See **Medical Necessity Appeals** in this section.

**Administrative Appeals**

Administrative appeals (benefit appeals that do not involve a medical necessity determination for commercial Members) of decisions issued by the Claims or Customer Service Department without the Medical Management Department’s involvement are handled by the Correspondence Unit.

If a Member would like to file an appeal on a claim determination, they must mail all administrative appeals to:

![Oxford Health Plans - Correspondence Unit](bridgepoint-ct-06601-7073)

Verbal appeals may be submitted, however, written submissions are encouraged to help ensure that all issues are identified. Verbal appeals from a third party will not be accepted without written authorization from the Member.
The request must be filed within **180 days** of the Member’s receipt of the adverse claim determination notice.

### Second-level Member Appeals

Members have the right to take a Second-Level Appeal to Oxford’s Grievance Review Board (GRB). If the Member remains dissatisfied with the First-Level Appeal determination, the Member or their authorized representative may appeal the First-Level medical necessity, benefit or administrative determination to the GRB for further consideration. Requests for a Second-Level Appeal must be made within 60 business days of receipt of the First-Level Appeal determination letter. Second-Level Appeal requests for Connecticut Members involving a benefit or administrative issue must be filed within 10 business days of receipt of the First-Level Appeal determination letter. The request for appeal and any additional information must be submitted to:

**Oxford | Important Address**

Grievance Review Board  
c/o Oxford Health Plans  
48 Monroe Turnpike  
Trumbull, CT 06611

The Member or their authorized representative will need to include all information requested previously by Oxford (if not already submitted), and include any additional facts or information that the Member believes to be relevant to the issue. The Member or their representative may send us written comments, documents, records, or other information regarding the claim.

### Member External Appeal Process

New York, New Jersey and Connecticut Members have the right to appeal a medical necessity determination to an external review agent. Information concerning the appropriate external appeal process will be detailed in the appeals attachment included with the initial determination and appeals determination.

### Consumer Complaints Sent to Regulatory Bodies

Members can file a consumer complaint with one of the following applicable regulatory bodies.

The applicable regulatory body is determined by the state in which the Member’s certificate of coverage was issued, not where the Member resides:

#### Connecticut

State of Connecticut Insurance Department  
153 Market Street  
P.O. Box 816  
Hartford, CT 06142-0816  
1-860-297-3862

#### Delaware

Delaware Department of Insurance  
1-800-282-8611 (in DE only)  
1-302-739-6775  
[www.state.de.us/inscom](http://www.state.de.us/inscom) (complaints can be filed online)

#### New York

Consumer Services Bureau  
State of New York Insurance Department  
25 Beaver Street  
New York, NY 10004-2349  
1-212-480-6400

Office of Managed Care  
Certification and Surveillance  
New York Department of Health  
Corning Tower, Room 1911  
Empire State Plaza  
Albany, NY 12237  
1-518-474-2121

#### New Jersey

Division of Insurance Enforcement and Consumer Protection  
20 West State Street  
P.O. Box 329  
Trenton, NJ 08625-0329  
1-800-446-7467 (In NJ only)  
1-609-292-5316

Department of Health and Senior Services  
Office of the Commissioner  
P.O. Box 360  
Trenton, NJ 08625  
1-609-633-0660
Pennsylvania
Pennsylvania Insurance Department
1-877-881-6388
www.insurance.state.pa.us/html/consumer.html
(complaints can be filed online)

Oxford Medicare Advantage℠
Member Appeals

The Centers for Medicare & Medicaid Services (CMS) has implemented a specific set of regulations for initial organization determinations, complaints, appeals, and grievances for Medicare+Choice Members. Medicare Member appeals are defined as those appeals resulting from an adverse determination that may result in Member liability. To determine whether or not there may be Member liability, please refer to the denial notice issued for the request for service or payment. All disputes that are not related to a denial of service or payment or are related to enrollment or hospice care are addressed through the Medicare grievance process. We will make all efforts to help this process run smoothly. In return, we ask for your cooperation. Oxford is responsible for gathering all necessary medical information. The Oxford Medicare Advantage Member’s enrollment form is an implied consent to the release of patient medical records, therefore it is critical that when we contact you for information related to an appeal, you provide us with the necessary information in a timely fashion. Oxford also gives Members the opportunity to provide additional information about their case in support of their position. All Oxford Medicare Advantage Member appeals must be submitted within 60 days of the initial adverse determination.

Assistance with Oxford Medicare Advantage Appeals/Reconsiderations

If an Oxford Medicare Advantage Member decides to appeal and would like assistance, he or she may have a friend, an attorney or other designee help with the appeal. There are several groups that can assist in submitting appeals such as a local Agency on Aging, the Senior Citizens Law Center, the Member’s state Ombudsman, or the Insurance Counseling and Assistance Program.

A third party may file an appeal on a Member’s behalf. If so, the party must complete the Representative of Appointment/Acceptance form or provide proof that he or she represents the Oxford Medicare Advantage Member by providing the Member’s name, the claim/reference number, the Member’s Oxford Medicare Advantage Member ID number, and a signed statement from the Member authorizing the third party representation.

Please note: Oxford is not authorized to process the appeal without this documentation. (This rule does not apply in the case of a physician requesting an expedited, 72-hour appeal).
To the extent provided under applicable law, a court-appointed legal guardian or an agent under a healthcare proxy may also file an appeal.

Non-participating facilities may file an appeal; however a Waiver of Liability statement must be completed, and the waiver must state that the provider will not bill the Oxford Medicare Advantage Member in the event the denial is upheld. Members may supply additional information for their appeal at any time.

Types of Appeals
* Expedited Appeals*
* Standard Service Appeals
* Denials of Skilled Nursing Facility, Home Health Aid or Comprehensive Outpatient Rehabilitation Facilities Appeals
* Payment (Claims) Appeals

If you have any questions as to whether or not a service is covered, or regarding a claim payment, please call the Oxford Provider Services Department at 1-800-666-1353 and if applicable, follow the in-office denial protocol.

To file a request verbally, please call Oxford Medicare Advantage Customer Service at 1-800-234-1228.

If Members would like to file an Expedited, Standard or Payment Appeal request in writing, they must hand-deliver or mail the appeal to:

**Mail:**
Oxford Health Plans
Medicare Complaints, Appeals and Grievances (CAG) Department
PO Box 7070
Bridgeport, CT 06601

**Hand-Deliver:**
Oxford Health Plans
48 Monroe Turnpike
Trumbull, CT 06611

Fax: 1-203-459-3326

In addition, Members may file requests with the Social Security Administration or, if they are railroad annuitants, with the Railroad Retirement Board office.

Please note: These offices will transfer the requests to Oxford for processing and the time frame will begin when Oxford’s Medicare CAG Department receives the written request.

Expedited Appeal Process for Oxford Medicare Advantage Members*

When Oxford’s Medical Management Department has determined that a requested service will not be covered, Members and/or their providers have the right to request an Expedited Appeal. If an Oxford Medicare Advantage Member (or his designee) would like to file an expedited appeal, he or she must hand-deliver, mail or fax a written request to Oxford or verbally request an expedited appeal by specifically stating, “I want an expedited reconsideration,” or “I believe that my (or the Member’s) health could be in jeopardy by waiting 30 days for a standard reconsideration.”

A Member can receive an expedited appeal only if requested and only if the case is one in which the standard 30-day time frame could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function or if the request is supported by a physician. If a Member’s request for an expedited reconsideration is denied, the request for appeal will be processed within the standard 30-day time frame and the Member will be notified.

Expedited appeals that are filed by physicians are deemed to be expedited. If the request is submitted in writing, the 72-hour expedited appeal time frame will begin when Oxford’s Medicare CAG Department receives the written request. The Member or Member’s designee may present additional information via telephone or in person at Oxford’s Trumbull, Connecticut office.

Time extension — An extension of up to 14 calendar days is permitted for an expedited reconsideration if the extension will benefit the Member. An example would be if the Member were required to have additional diagnostic tests performed to confirm a diagnosis.

* An expedited appeal must be concurrent or prior to services being rendered.
Standard Service Appeal Process for Oxford Medicare Advantage™ Members

When Oxford’s Medical Management Department has issued an adverse determination (denial) for a service that has not yet occurred or for a concurrent service with Member liability, the Member or his or her designee can file a Standard Service Appeal. Standard Service Appeals must be submitted in writing and must be filed within 60 days of the initial denial determination notice. Standard Service Appeals are reviewed and determinations are made within 30 days of receipt of the appeal request.

Appeals for Denials of Skilled Nursing Facility (SNF), Home Health Care (HHC) or Comprehensive Outpatient Rehabilitation Facility (CORF)

When Oxford’s Medical Management Department has determined that a request for a SNF, HHC or CORF will not be covered or will be discontinued, the Member, his or her designee and/or provider has the right to request a Fast Track Appeal through the Quality Improvement Organization (QIO) an independent review entity upon receipt of the Notice of Medicare Non-Coverage. If a Member or designee on behalf of a Member would like to file a Fast-Track Appeal, he or she must hand-deliver, mail or fax a written request to the QIO in their state, or verbally request a Fast-Track Appeal by specifically stating, “I want a Fast-Track Appeal,” by noon of the day after he or she receives the initial denial notice from Oxford. The appeal can be filed with Oxford directly at any time or in the event that the noon deadline is missed. If filed with Oxford, the Expedited 72-hour Appeal or Standard Service Appeal process must be followed.

The QIO differs for each state, as follows:

New York
IPRO
1979 Marcus Avenue
Lake Success, NY 11042-1002
1-800-331-7767

New Jersey
PRO of New Jersey, Inc.
557 Cranbury Road
East Brunswick, NJ 08816-4026
1-800-624-4557 or 1-732-238-5570

Connecticut
QUALIDIGM
100 Roscommon Drive
Middletown, CT 06457
1-800-553-7590 or 1-860-632-2008

Payment (Claims) Appeal Process for Oxford Medicare Advantage Members

When the Oxford Claims Department has issued a denial on a claim which results in Member liability, the Member or his or her designee can file a Payment Appeal. Payment Appeals must be submitted in writing and must be filed within 60 days of the denial determination notice.

Oxford Medicare Advantage Member Adverse Determinations on Appeal

Oxford is responsible for processing an Expedited Appeal within 72 hours, a Standard Service Appeal within 30 days and a Payment (claims) Appeals within 60 days of the date we receive the request. If Oxford does not rule fully in the Member’s favor, we will forward the appeal request to the CMS contractor, which is the Center for Health Dispute Resolution (CHDR). CHDR will then render a decision and will send the Member a letter informing him or her of its decision within 30 business days for Standard Service Appeals, within 60 days for Payment Appeals, and within 10 business days for Expedited Appeals of receiving the case from Oxford.

The CHDR may request additional information from your office prior to making a reconsideration decision. CHDR will notify Oxford’s Medicare Complaints, Appeals and Grievances Department, which will in turn notify your office. Your timely attention to this request is required. Upon issuing a reconsideration determination, CHDR will advise the Member (and/or representative) of the decision, the reasons for the decision and, if applicable, the right to a hearing before an Administrative Law Judge of the Social Security Administration.

In the event of an adverse determination from CHDR, Oxford Medicare Advantage Members may request a hearing before an Administrative Law Judge by writing to CHDR or to a Social Security office within 60 days of the date of notice of an adverse reconsideration decision.
This 60-day notice may be extended for good cause. A hearing can be held only if the amount in controversy is $100 or more (as determined by the Administrative Law Judge).

The Administrative Law Judge’s adverse decision can be reviewed by the Appeals Council of the Social Security Administration, either by its own action or as the result of a request from the Member or Oxford. If the amount involved is $1,000 or more, either the Member or Oxford can request that a decision made by the Appeals Council or Administrative Law Judge be reviewed by a federal district court.

An initial, revised or reconsideration determination made by Oxford, CHDR, the Administrative Law Judge, or the Appeals Council can be reopened:

• Within 12 months
• Within four (4) years, with just cause
• At any time for clerical correction or in cases of fraud

Grievances

Commercial Member Complaints and Grievances

If Oxford does not fully grant a Member’s appeal for services, the Member can file a grievance with:

Oxford Health Plans
Grievance Review Board
48 Monroe Turnpike
Trumbull, CT 06611

A Member’s right to go to external review is contingent on the plan type and relevant state law. Information on conducting the external process will be provided with appeal determination letters.
Oxford Medicare Advantage™ Complaints and Grievances

Oxford’s Medicare Advantage Members have the right to file grievances regarding Oxford or Oxford’s contracting medical providers. The Oxford Medicare Advantage grievance procedure provides for the meaningful, dignified, confidential, and timely resolution of those grievances.

An Oxford Medicare Advantage Member has the right to file a complaint/grievance about:

- Quality-of-care issues
- Office waiting times
- Physician behavior
- Premiums
- Involuntary disenrollment
- A request for expedited determination or appeal that has been denied and transferred to the standard process
- Any other issues concerning the quality of care or service received as an Oxford Medicare Advantage Member
- Balance billing issues

Filing a Grievance

We encourage the informal resolution of Member complaints (i.e., over the telephone), especially if such a complaint is the result of misinformation, misunderstanding or lack of information. If the Member’s complaint cannot be resolved quickly by telephone, it will be handled through Oxford’s formal grievance procedure. A formal Medicare grievance will be handled in a timely manner by the appropriate department at Oxford.

Oxford will acknowledge the receipt of the Member’s formal grievance in writing within 15 days of receipt and will provide a written resolution within 45 days after receipt of the information needed to make a determination.

Members who choose to submit a grievance in writing, should use the following addresses:

OXFORD | IMPORTANT ADDRESS

For complaints about Oxford’s contracting medical providers (e.g., quality of care, office waiting time, physician behavior, adequacy of facilities):

Oxford Health Plans
Quality Management
Westchester One, 14th Floor
44 South Broadway
White Plains, NY 10601

For complaints about balance billing:

Oxford Health Plans
Medicare Complaints, Appeals, and Grievances Department
P.O. Box 7070
Bridgeport, CT 06601-7070

For any other Member complaints (e.g., disenrollment, premiums, Oxford policies, Oxford service):

Oxford Health Plans
P.O. Box 7070
Bridgeport, CT 06601-7070