



APPEAL REQUEST FORM

If you have received a denial from Sonder Health Plans and do not agree with the Plan’s initial determination, you may submit a request for reconsideration or redetermination (a First Level “Appeal”) to the Plan. Please use this Form to submit your request to Appeal.

Appeals must be filed with the Plan no later than 60 days from the date of the initial denial. The Plan may accept a late filing as a good cause exception if an explanation to why the request wasn’t filed on time is provided to the Plan in writing.

To submit a request for an Appeal to Sonder Health Plans, please complete the Appeal Request Form and submit it, along with any supporting documents to the Plan by mail, fax, or electronically on our website at the below:

Mail to:
Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

Fax to:
(941) 866-2319

Website: <https://www.sonderhealthplans.com/exceptions-and-appeals>

If you have any questions or need assistance with this form, please call the Grievance and Appeals Department directly at (888) 428-2110, Option 2; TTY 711, Monday-Friday from 8 a.m. - 5 p.m.

Member Information

Name (first and last): _____

Member Date of Birth: _____ Member Sonder Plan ID: _____

Street Address: _____

City: _____ Zip: _____ Phone: _____

If you are not the Member or a Contracted Provider submitting on behalf of the Member, additional documentation is required to process the request for an Appeal. An Appointment of Representative (AOR) Form must be completed by individuals acting as Member Representatives, signed by the Member, and dated within a year to be valid; other legal forms of legal representation, such as power of attorney and health care surrogate documents are accepted for review. A Waiver of Liability (WOL) Form must be completed and signed by Non-Contracted Providers wishing to appeal claim denials. Both forms can be located on our website at: <https://www.sonderhealthplans.com/exceptions-and-appeals>. You can also request the forms from Member Services at (888) 428-4440.

Appeal Information

Indicate if this is a Part C (Medical Service/Device/Part B Drug) or Part D (Medication) Appeal:

Part C Appeal Request Part D Appeal Request

Indicate if this is Pre-Service (authorization denial) or Post-Service (claim/payment denial) Appeal:

Pre-Service (did not received service/drug) or Payment/Claim Denial

Authorization #: _____ Claim #: _____

Date(s) of Service (if service has not been received, enter N/A or): _____

Select service type and add description as applicable:

Medical Service(s) Description: _____

Medical Device(s) Description: _____

Medication/Drug: _____

Reason you are appealing:

Supporting Documentation Attached

What attachments (if any) are you including with this completed form:

Explanation of Benefits Letter from your doctor AOR Form
 Notice of Denial Bill Received WOL Form
 Provider Remittance Advice Medical Record(s) Other: _____

Do you need an Expedited Appeal?

Select if applicable:

Yes, because in the requestor believes that applying the standard processing timeframes could seriously jeopardize Member's health, life, or ability to regain maximum function.

Yes, because requestor has included a letter from the Member's physician or the prescribing indicating that applying the standard timeframes could seriously jeopardize the Member's health, life, or ability to regain maximum function.

How long will Sonder Health Plans take to process your request for an Appeal?

Part C Appeals (Medical Services/Devices/Part B Drugs):

Sonder Health Plans will process Part C Appeals as quickly as possible and based on the Members health status, but will process standard pre-service appeals no later than 14 days from the receipt of the request, or within 72 hours for expedited pre-service appeals. For Part B Drugs we will process standard appeals no later than 72 hours from the receipt for standard requests, or 24 hours for expedited requests. For payment appeals we will process your requests within 60 days from the receipt of the request.

Part D Appeals (Medications):

When medication/drugs have not been obtained by the Member, Sonder Health Plans will process Part D Appeals as quickly as possible, but no later than 72 hours from the receipt of a standard request, or within 24 hours for expedited requests. For payment appeals we will process your request within 14 days from the receipt of the request.

Note: Sonder Health Plans may take a 14-day extension if the Member requests the extension, or if the Plan needs additional information and feels the delay is in the best interest of the Member. If Sonder Health Plans takes an extension, we will notify the Member in writing of the extension and explain the reason for the delay.

Processing timeframes for Standard Appeal Requests begin when the Plan receives the request, however, for Expedited Appeal Requests they begin when the Grievance and Appeals Department receives the request.

Payment denials for Contracted-Providers are governed and processed per contracted appeals/dispute resolution language in the Provider Agreement and/or per extended language in the Provider Manual.

Requestor Information

Who is requesting the Appeal? Please select Requestor Type:

- I am the **Member** related to this complaint
- I am the **Member's Legal Representative** (AOR Form or other Legal Documentation Required)
- I am a **Contracted Provider** (submitting on behalf of the Member)
- I am a **Non-Contracted Provider** (WOL Form Required)

Submitter Name (Print first and last): _____

Submitter Signature (optional): _____ Date: _____

Out-of-network/non-contracted providers are under no obligation to treat Sonder Health Plans' Members, except in emergency situations. Please call our Member Service number or see your Evidence of Coverage for more information, including the costs-sharing that applies to out-of-network services.

Sonder Health Plans, Inc. is an HMO with a Medicare contract. Enrollment in Sonder Health Plans depends on contract renewal.

IMPORTANT MEMBER INFORMATION

Discrimination is against the law. Sonder Health Plans, Inc. does not and shall not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Sonder Health Plans complies with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Sonder Health Plans, there are ways to get help. You may file a complaint, also known as a grievance, with us at:

Sonder Health Plans
ATTN: Grievance & Appeals Department
6190 Powers Ferry Road, Suite 320
Atlanta, GA 30339

If you need help filing a grievance, call Sonder Member Services department at 1 (888) 428-4440, TTY 711. We are open 8 a.m. to 8 p.m. seven days a week from October 1st to March 31st, and 8 a.m. to 8 p.m. Monday-Friday from April 1st to September 30th. You may also leave a voicemail after hours, Saturdays, Sundays, and holidays and we will return your call within one business day.

Additionally, you have the right to file a civil rights complaint with the U.S. Department of Health and Human Services (HHS), Office for Civil Rights (OCR), electronically through the OCR Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf>, or by mail or phone at U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TDD 1-800-537-7697). Complaint forms are also made available at <https://www.hhs.gov/ocr/complaints/index.html>.

Sonder Health Plans provides auxiliary aids and services, free of charge, such as qualified sign language interpreters and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate, contact 1-888-428-4440 (TTY: 711) for assistance.

Language assistance services are available to you, free of charge, call 1-888-428-4440 (TTY: 711) for assistance.

Español (Spanish): Llame al número arriba para recibir servicios gratuitos de asistencia lingüística.

Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.

Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.

Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.

Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.

Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.

Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.

繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。

Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.

한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오.

Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.

Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.

ગુજરાતી (Gujarati): નિ:શુલ્ક ભાષા સહાય સેવાઓ પ્રાપ્ત કરવા માટે ઉપરોક્ત નંબર પર કોલ કરો.

ภาษาไทย (Thai): โทรติดต่อที่หมายเลขด้านบนนี้เพื่อรับบริการช่วยเหลือด้านภาษาโดยไม่เสียค่าใช้จ่าย.

Diné Bizaad (Navajo): Wóda'í béésh bee hani'í bee wolta'ígíí bich'í'í' hódíílnih éí bee t'áá' jiik'eh saad bee áká'ánída'áwo'déé' níká'adoowól.

العربية (Arabic): الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك