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://sonderhealthplans.com/for-members/member-guidance/grievances-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 1; 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://sonderhealthplans.com/for-members/member-guidance/grievances-and-appeals/

You can also request the forms from Member Services at (888) 428-4440.

Appeal Information

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.

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-haring 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.