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 receive 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 cost-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.

Form Approved
OMB# 0938-1421

Multi-Language Insert

Multi-language Interpreter Services

English: We have free interpreter services to answer any questions you may have about our health or drug plan. To get an interpreter, just call us at 1-888-428-4440. Someone who speaks English/Language can help you. This is a free service.

Spanish: Tenemos servicios de intérprete sin costo alguno para responder cualquier pregunta que pueda tener sobre nuestro plan de salud o medicamentos. Para hablar con un intérprete, por favor llame al 1-888-428-4440. Alguien que hable español le podrá ayudar. Este es un servicio gratuito.

Chinese Mandarin: 我们提供免费的翻译服务，帮助您解答关于健康或药物保险的任何疑 问。如果您需要此翻译服务，请致电 1-888-428-4440。我们的中文工作人员很乐意帮助您。 这是一项免费服务。

Chinese Cantonese: 您對我們的健康或藥物保險可能存有疑問，為此我們提供免費的翻譯 服務。如需翻譯服務，請致電 1-888-428-4440。我們講中文的人員將樂意為您提供幫助。這 是一項免費服務。

Tagalog: Mayroon kaming libreng serbisyo sa pagsasaling-wika upang masagot ang anumang mga katanungan ninyo hinggil sa aming planong pangkalusugan o panggamot. Upang makakuha ng tagasaling-wika, tawagan lamang kami sa 1-888-428-4440. Maaari kayong tulungan ng isang nakakapagsalita ng Tagalog. Ito ay libreng serbisyo.

French: Nous proposons des services gratuits d'interprétation pour répondre à toutes vos questions relatives à notre régime de santé ou d'assurance-médicaments. Pour accéder au service d'interprétation, il vous suffit de nous appeler au 1-888-428-4440. Un interlocuteur parlant Français pourra vous aider. Ce service est gratuit.

Vietnamese: Chúng tôi có dịch vụ thông dịch miễn phí để trả lời các câu hỏi về chương sức khỏe và chương trình thuốc men. Nếu quí vị cần thông dịch viên xin gọi 1-888-428-4440 sẽ có nhân viên nói tiếng Việt giúp đỡ quí vị. Đây là dịch vụ miễn phí .

German: Unser kostenloser Dolmetscherservice beantwortet Ihren Fragen zu unserem Gesundheits- und Arzneimittelplan. Unsere Dolmetscher erreichen Sie unter 1-888-428-4440. Man wird Ihnen dort auf Deutsch weiterhelfen. Dieser Service ist kostenlos.

Korean: 당사는 의료 보험 또는 약품 보험에 관한 질문에 답해 드리고자 무료 통역 서비스를 제공하고 있습니다. 통역 서비스를 이용하려면 전화 1-888-428-4440 번으로 문의해 주십시오. 한국어를 하는 담당자가 도와 드릴 것입니다. 이 서비스는 무료로 운영됩니다.

Russian: Если у вас возникнут вопросы относительно страхового или медикаментного плана, вы можете воспользоваться нашими бесплатными услугами переводчиков. Чтобы воспользоваться услугами переводчика, позвоните нам по телефону 1-888-428-4440. Вам окажет помощь сотрудник, который говорит по-русски. Данная услуга бесплатная.

Arabic: إننا نقدم خدمات المترجم الفوري المجانية للإجابة عن أي أسئلة تتعلق بالصحة أو جدول الأدوية لدينا. للحصول على مترجم فوري، ليس عليك سوى الاتصال بنا على 1-8884284440. سيقوم شخص ما يتحدث العربية بمساعدتك. هذه خدمة مجانية.

Hindi: हमारे स्वास्थ्य या दवा की योजना के बारे में आपके किसी भी प्रश्न के जवाब देने के लिए हमारे पास मुफ्त दुभाषिया सेवाएँ उपलब्ध हैं. एक दुभाषिया प्राप्त करने के लिए, बस हमें 1-888-428-4440 पर फोन करें. कोई व्यक्ति जो हिन्दी बोलता है आपकी मदद कर सकता है. यह एक मुफ्त सेवा है.

Italian: È disponibile un servizio di interpretariato gratuito per rispondere a eventuali domande sul nostro piano sanitario e farmaceutico. Per un interprete, contattare il numero 1-888-428-4440. Un nostro incaricato che parla Italianovi fornirà l'assistenza necessaria. È un servizio gratuito.

Portuguese: Dispomos de serviços de interpretação gratuitos para responder a qualquer questão que tenha acerca do nosso plano de saúde ou de medicação. Para obter um intérprete, contacte-nos através do número 1-888-428-4440. Irá encontrar alguém que fale o idioma Português para o ajudar. Este serviço é gratuito.

French Creole: Nou genyen sèvis entèprèt gratis pou reponn tout kesyon ou ta genyen konsènan plan medikal oswa dwòg nou an. Pou jwenn yon entèprèt, jis rele nou nan 1-888-428-4440. Yon moun ki pale Kreyòl kapab ede w. Sa a se yon sèvis ki gratis.

Polish: Umożliwiamy bezpłatne skorzystanie z usług tłumacza ustnego, który pomoże w uzyskaniu odpowiedzi na temat planu zdrowotnego lub dawkowania leków. Aby skorzystać z pomocy tłumacza znającego język polski, należy zadzwonić pod numer 1-888-428-4440. Ta usługa jest bezpłatna.

Japanese: 当社の健康 健康保険と薬品 処方薬プランに関するご質問にお答えするために、無料の通訳サービスがありますございます。通訳をご用命になるには、1-888-428-4440 にお電話ください。日本語を話す人 者 が支援いたします。これは無料のサービスです。