

## **Medical Determinations – Part C**

### **Pre-Service Determinations**

When you, your doctor or your representative request an authorization for a service or benefit, MCA will notify you of our determination by mail not later than 14 calendar days after we receive your request. If you or your doctor requests a fast (expedited) review, and we agree that waiting for the standard timeframe of 14 days will seriously affect your life, health or ability to regain maximum function, we will notify you by telephone of our determination not later than 72 hours after we receive your request. If we do not agree a fast review is required, we will notify you and automatically move your request to the standard review process. If our determination is unfavorable to you, you or your representative may file an appeal of our decision. For more information refer to the Evidence of Coverage, Chapter 4 to see what is covered and Chapter 9 for how to make a request for services. [Click here for Evidence of Coverage](#)

### **Payment Determinations**

When you receive health care from providers, they must submit a claim for those services. Claims are paid based on the information the provider supplies and your benefits under Mercy Care Advantage. If payment for a claim is denied, and we believe you may be responsible for the payment, we will send you a letter that explains why we did not pay for the services. You or your representative has the right to appeal the determination.

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Some examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received include: when you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network or when a network provider sends you a bill you think you should not pay.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. You can get a copy of our reimbursement claim form on our

website or by calling Member Services. **Please include your receipt(s) with your written request.**

Please send your written reimbursement request to:

Mercy Care Advantage (HMO)

Member Services

4350 E. Cotton Center Blvd.

Building D

Phoenix, AZ 85040

### **Appointment of Representative**

You may appoint someone (your doctor, family member, friend, etc.) to act on your behalf during the Appeals process. Both you and the person you selected must fill out and sign an **Appointment of Representation Form** and mail it or FAX it to the Appeals Department with your appeal at the address or FAX number listed below. [Click HERE](#) for the form and instructions on how to fill out the form. The completed and signed form is valid for one (1) year.

If your representative holds durable power of attorney or guardianship papers, an Appointment of Representative form is not required.