sunshine health™

Medicaid Member and Provider Appeals Processes

At Sunshine Health, both members and providers have the right to appeal decisions that affect their care and services. Understanding the differences and similarities between the member and provider appeal processes is crucial for ensuring transparency and fairness. This document provides a side-by-side comparison of the appeal processes for members and providers, highlighting the key steps, timelines and requirements involved. By familiarizing yourself with these processes, you can better navigate the system and advocate effectively for your needs or the needs of those you serve.

	Member Appeal	Provider Appeal
Appeal Definition	A request from a member or member representative related to a medical necessity decision to reduce, terminate, suspended or deny services.	A request from a provider related to a medical necessity decision or authorization-related issues for post-service claim denial.
Who can file?	Member or member representative. This includes providers with signed member consent.	The direct service provider or member's PCP.
When does the appeal need to be filed?	60 days from the date of the Notice of Adverse Benefit Determination (NABD).	**1st Level Appeal (Reconsideration):** Must be filed within 90 days from the original Explanation of Payment (EOP). **2nd Level Appeal (Dispute):** Must be filed within 90 days from the original Appeal Denial Notice. **Note:** Appeals made prior to the EOP will be closed as invalid. There will be no denial in our system to appeal.

	Member Appeal	Provider Appeal
Are there documents that must be included with the appeal?	None required. However, including all necessary records to support the appeal is suggested. Sunshine Health will make efforts to secure required medical records.	Yes. Include a claim adjustment request form and a written statement outlining the reason(s) why they disagree with the initial determination. It must also include a claim number, authorization number (if applicable) and medical records. The request should also include records specific to the member's health for "all" dates of service in question. If no claim adjustment request form or medical records are included, it will be closed as an invalid appeal.
Are any forms required?	Signed consent is required when anyone other than the member is appealing.	Yes. Visit **SunshineHealth.com/resources** to download the Provider Claim Adjustment Request Form (PDF).
Where does the appeal get filed?	Member appeals can be filed orally or in writing. Mail: Sunshine Grievance & Appeals P.O. Box 459087 Fort Lauderdale, FL 33345-9087 Fax: 1-866-534-5972 Phone: 1-866-796-0530 (TTY 1-800-955-8770) Email: Sunshine_Appeals@centene.com	Mail 1st and 2nd Level Appeals to: Sunshine Health P.O. Box 3070 Farmington, MO 63640-3823 Fax: 1-833-504-0580
How long does it take to review?	Standard appeal within 30 days. Expedited appeal within 48 hours.	Standard appeal within 60 days.
Can the appeal be escalated?	Providers may request an "expedited plan appeal" on their patients' behalf if they believe that waiting 30 days for a resolution would put their life, health or ability to attain, maintain or regain maximum function in danger. Expedited requests do not require a member's written consent for the providers to appeal on the member's behalf.	No.
Can services be continued during the appeal process?	Yes. Request must be made within 10 days after the NABD, or on or before the first day that services will be reduced, suspended or terminated. Providers may make this request if they are acting as the member's representative. If services are continued, member may be liable for services if the final decision is not in their favor (upheld/denied).	N/A
What if I am not satisfied with initial appeal?	Member or member representative may ask for a Medicaid Fair Hearing at any time up to 120 days after the Notice of Plan Appeal Resolution (NPAR). Title XXI members are not allowed to have a Medicaid Fair Hearing. Title XXI members may file an External Review with the plan. Plan will utilize an Independent Review Organization (IRO) to conduct an External Review.	1st Level Appeal (Reconsideration) 2nd Level Appeal (Dispute) Provider Complaint