Davis Vision appeals and grievance rights information

Regulatory agencies and accrediting bodies have strict requirements for handling appeals, complaints and grievances. These requirements specify timeframes for acknowledging, reviewing and replying to issues. The requirements also specify what information must be communicated to the member such as the reason for a denial and the member's appeal rights. Most states have also developed programs to provide independent review of cases involving a dispute between health plans and consumers.

Davis Vision has a full and fair process for resolving member disputes and responding to member requests to reconsider a decision they find unacceptable regarding their care and service. Because Davis Vision provides routine vision and eye care services with frequency limitations selected by the client, most determinations are based solely on whether or not the member has an available benefit.

Member Services Representatives (MSR) can provide more information about how your coverage was applied and answer any questions you may have about your benefits. To reach a representative, please call 1-800-999-5431.

If all or part of a claim was not covered, you have a right to see, upon request and at no charge, any rule, guideline, protocol or criterion that Davis Vision, Inc. relied upon in making the coverage decision. If a coverage decision was based on medical necessity or the experimental nature of the care, you are entitled to receive upon request and at no charge the explanation of the scientific or clinical basis for the decision as it relates to the patient's medical condition.

If after speaking with a MSR you feel that our coverage decision was not correct, the patient or an authorized representative may appeal the decision by following the steps below.

How to appeal or grieve a coverage decision

To appeal or grieve a coverage decision, please send to the address below a written explanation of why you feel the coverage was incorrect. Unless your plan specifies otherwise, this information may also be provided to a MSR over the phone. Please include with the explanation:

- The patient's name, relationship to member, address and telephone number
- Your Davis Vision, Inc. identification number
- If applicable, the name of the health care professional or facility that provided the service, including the date and description of the service(s) provided and the charge(s)

Send written appeals to:

Davis Vision, Inc.
Attention: Complaints and Appeals Department
P.O. Box 791
Latham, NY 12110

Members must file an appeal within 180 days of the date of this Explanation of Benefits notification of coverage decision. In most cases, unless shorter timeframes are required by law, Davis Vision will respond in writing as fast as your condition requires, but no later than the following response times:

- Urgent Requests - 72 hours
- Pre-Service Requests - 15 days
- Post-Service Requests - 30 days

If you are a member of an ERISA-regulated group health care plan and you have completed the appeals process without satisfaction, you may have the right to bring civil action under 502 (a) of ERISA. Federal, state and local government programs, church plans, and individual policies are not regulated by ERISA.