

# **OHIO LABORERS' DISTRICT COUNCIL-OHIO CONTRACTORS' ASSOCIATION INSURANCE FUND**

## **PROCEDURES FOR APPEAL AND REVIEW**

You, your beneficiary (when an appropriate claimant) or duly authorized representative may appeal any denial of a claim for benefits by filing a written request, stating fully the reasons for the filing of an appeal, for a full and fair review to the Board of Trustees.

**You have the right to one (1) mandatory appeal through Medical Mutual of Ohio.**

**For requests for appeal or adverse determinations related to claims payment, administrative decisions or benefit denials, providers must send or fax a copy of the denial notice, a completed Provider Action Request, (PAR) form and any additional information or records to Medical Mutual, P.O. Box 94917, Cleveland, Ohio 44101-4917 or fax to (216) 687-2614.**

If after the mandatory appeal, you are still dissatisfied with the decision you may file a voluntary appeal to the Board of Trustees.

In connection with such a request, documents pertinent to the administration of the Plan may be reviewed and comments and issues outlining the basis of the appeal must be submitted in writing. You may have representation throughout the review procedure. A request for a review must be filed by 60 days after receipt of the written denial of a claim. The full and fair review will be held and a decision rendered by the Board of Trustees no later than 60 days after the receipt of the written request detailing the basis for review. If there are special circumstances, the decision will be made as soon as possible no later than 120 days after receipt of the request for review. If such an extension of time is needed you will be notified in writing prior to the beginning of the time extension period. The decision after the Board review will be in writing and will include specific reasons for the decision as well as specific references to the pertinent Plan provisions on which the decision is based.

**NOTE: ONLY APPEALS IN WRITING GIVING SPECIFIC REASONS AND/OR ISSUES FOR THE BASIS OF THE APPEAL WILL BE CONSIDERED BY THE BOARD OF TRUSTEES.**

**Attached is an appeal form that may be used to submit your request to the Board of Trustees. A signature of the member, beneficiary or duly authorized representative submitting the appeal is required.**

Appeals should be addressed to:

Appeals Review Committee  
Ohio Laborers' District Council-  
Ohio Contractors' Association Insurance Fund  
800 Hillsdowne Road  
Westerville, Ohio 43081

<b>OLDC-OCA INSURANCE FUND MEMBER APPEAL FORM</b>
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**\*Denotes a required field**

<b>*Member Name</b>	<b>*Member Social Security #</b>	<b>*Daytime Phone</b>

<b>*Street Address</b>	<b>*City</b>	<b>* State</b>	<b>* Zip</b>

If appeal is for a covered dependent complete the following section:

<b>*Dependent's Name</b>	<b>*Relationship to Member</b>	<b>*Dependent's Date of Birth</b>

Please check reason for appeal:

- Insurance terminated for non-payment, late payment (including check returned for non-sufficient funds).
- Reinstatement of disability waiver.
- Denial of a medical, vision or prescription claim.
- Denial of an accident & sickness (short-term disability) claim.
- Other

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If the appeal is due to a denial of a medical claim, please complete the following sections:

Provider(s) Name (hospital/physician/other provider) and Address:

1.

2.

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Date of Service	Date of Service
Claim Number (attach EOB if available)	

Please describe why you want the Insurance Board of Trustees to reconsider this denial (Please print and attach additional information as needed such as letter from the provider, medical records to support the necessity of the service, etc.)

If this is a request for reinstatement of disability waiver or reinstatement of insurance due to non-payment, late payment or reversal of payment due to non-sufficient funds, please describe circumstances below. (**Attach additional sheet if necessary**).

*Signature of member or covered dependent	*Date

**\*\*Signature is required\*\***