AKWESASNE NON-INSURED HEALTH BENEFITS

APPEAL PROCESS

TERMS OF REFERENCE

An appeal can be requested to challenge any decision pertaining to the denial of benefits made by the Akwesasne Non-Insured Health Benefits (ANIHB) Program.

Appeals will be considered in the following areas:

Medical Supplies & Equipment	Co-Payment
Dental	Vision
Allied Health	Pharmacy
Medical Transportation.	

In instances where a member of Akwesasne feels that they require specialized health benefits not covered by ANIHB, or for incidents that challenge the current ANIHB policies, the following procedure will be followed on a case by case basis to address their need.

The person(s) requesting an appeal must be the applicant or recipient/unless the child is a minor.

Levels of Appeal:

The Appeal will be presented on the Mohawk Council of Akwesasne approved form as attached to this policy.

1. The person(s) initiating the appeal must apply in writing to the Program Manager (PM) of the Akwesasne Non-Insured Health Benefits Program; the Program Manager is to be person of the first contact. The Program Manager will review the case, document a brief history, list which ANIHB policy the benefit challenges, cost implications, and form a decision in Section A. The decision of the Program Manager is indicated by circling the appropriate action.

   If the Program Manager feels that the Appeal is beyond their scope of authority, the Program Manager will include all relevant information and then prepare Section B. This act forwards the Appeal to the next level, review by the Akwesasne Non Insured Consultant.

2. The Consultant will review the case, form a decision and provide documentation of her/his decision in Section B of the form. Should the denial be upheld, the client will indicate their wish to proceed to the next level then case will be forwarded to the Director of Health and may be reviewed by the Appeal Board.

3. The Appeal Board will be assembled to review the case facts and make a recommendation to uphold the decision of the Akwesasne Non-Insured Health Benefits Program or choose and alternative action that will adequately reflect the limits of the budget constraints within the Department of Health. This will be documented in Section C of the form.

   The Akwesasne Non-Insured Health Benefits Program Appeal Board is comprised of:

   - A quorum of the Health Advisory Board members

The role and function of the Appeal Board is to provide a forum for community members/clients to request a review of denials or reduction of services from The Akwesasne Non-Insured Health Benefits Program.

The ANIHB Program Manager will provide a brief unbiased outline/history of the case and present her/his comments in writing on the Appeal Form, to the Appeal Board.

The Appeal Board will meet on an ad-hoc basis as deemed necessary. All information relevant to the board will be held in strict confidence with any personal indicators to be removed prior to the board reviewing its case.

The appeal board will be responsible for assessing the overall facts as presented to determine the validity of the decision.

Upon review of the case, the Appeal Board will form a recommendation based upon majority vote, which will be relayed to the client by way of correspondence from the Program Manager. If the appeal is denied at this level, justification will be provided. If members of the Appeal Board wish to indicate their decision alongside their signatures they may do so.

The decision of the Appeal Board is final and conclusive.

All discussions and facts relevant to the case will be documented and placed in the case files in the ANIHB office. All correspondence to the parties in the Appeal will be kept on record. Every avenue will be made available for all parties of the appeal to be heard and investigations will be complete and documented.

FOR OFFICE USE ONLY

Appeal #_____ FY20 _ _/20 _ _
Program Benefit: _____

Akwesasne Non-Insured Health Benefits Program
Appeal Form

Name of Applicant: _____ DIAND/Band# 159_____

Health Card **#:**_____ Exp: _____

Address _____

_____

Elder Pension: ☐ Yes ☐ No

Community Support Akwesasne: ☐ Yes ☐ No Name of Worker:_____

Insurance: Employer: _____ Policy: _____

Hereby request a formal appeal to the ANIHB Program Manager, Director, Appeal Board.

Please list the Benefit that was denied:

_____
_____
_____

Reason for Denial (if known):

_____
_____
_____
_____

Please explain why you feel that receiving this benefit is important:

_____
_____
_____
_____
_____
_____

I, certify that all statements made in this written request for an appeal are true and that any false statements will directly affect my eligibility.

Further, I understand that the decision of the Appeal Board is final and conclusive.

_____ _____
Initial Date

SECTION A: FOR OFFICE USE ONLY

As Program Manager of ANIHB the client has been denied benefits because of ANIHB Policy#_____, violating the clause:

☐ **Frequency Violation** ☐ **Non-Benefit** ☐ **Other: _____**

Brief history of the client within ANIHB:_____

_____

_____

_____

Cost Implications: _____

In the scope of my authority, I ☐ APPROVE or ☐ DENY the aforementioned appeal, or if I feel it is not within my power to make this decision I choose to ☐ FORWARD this appeal on to the next level. (My decision is indicated by checking the box next to the appropriate action.)

_____ _____

ANIHB Supervisor/Program Manager Date

SECTION B: FOR OFFICE USE ONLY

The ANIHB Program Manager has estimated the cost implication of the benefit is roughly $_____, and that the ANIHB last quarter MCA Variance report showed a SURPLUS / DEFICIT (circle one).

Recommendation of the Program Manager, or any extenuating circumstances that should be considered in reviewing the appeal:

_____

_____

_____

PM Initial: _____ Date: _____

Therefore, as Director of Health, or ANIHB Consultant, it is in my authority to APPROVE or DENY the aforementioned appeal, or if I feel it is not within my power to make this decision, I choose to FORWARD this appeal on to the next level. (My decision is indicated by circling the appropriate action.)

Comments: _____

_____

_____

_____

_____ _____

ANIHB Consultant Date

_____ _____

Director of Health Date

CONSENT FORM

AKWESASNE NON-INSURED HEALTH BENEFITS
P.O. BOX 941 CORNWALL, ONTARIO K6H 5V1
Tel: 613-575-2341 Fax: 613-575-1153 Toll Free: 1-888-514-1966

PART 1

SURNAME:	**GIVEN NAME:**
DIAND NUMBER:	**DATE OF BIRTH:**
ADDRESS:	**CITY:**
PROVINCE:	**POSTAL CODE:**
TEL. NUMBER:	**HEALTH CARD #** **EXP**

PART 2

What the personal information is used for:

- Confirming/verifying eligibility for ANIHB Program
- Processing claims and payments to approved Health Care Providers
- Drug Utilization reviews
- Audits and verifications
- Appeals processing, and
- Purposes directly related to the administration, delivery and management of the ANIHB

PART 3

CONSENT:

By signing below I:

(A) Confirm that I have read and understand the content of this consent form or that it's been read or translated for me:

(B) Give my consent for Akwesasne Non-Insured Health Benefits Program (ANIHB), its agents/contractors, the claims administrators/ processors or others who provide health care benefits, items or services according to the ANIHB Program to collect, use disclose and share information about me for the purposes of the ANIHB Program.

(C) Understand that personal information will not be collected, used, disclosed and shared for other purposes or with other parties not listed above, unless I give my consent or as authorized or required by laws; and

(D) Declare that all information provided by me upon completion of this Consent Form, is true and accurate, and that any false answer or declaration may lead to a denial of benefits.

(E) Understand that should the ANIHB Program be discontinued for any reason, my consent form will be null and void.

Part 4

RECIPIENT:	
Signature:	**Date:**

RELATIONSHIP TO CHILD/CHILDREN UNDER THE AGE OF 18 AND/OR INCAPACITATED PERSONS:

FOR ANIHB OFFICE USE ONLY:
Witness: **Date:**