

## COMMUNITY LEGAL SERVICES

### Maricopa County Central Office

305 South Second Avenue  
Phoenix, Arizona 85003  
(602) 258-3434 1-800-852-9075 TTY: (602) 254-9852

**You may apply for free services at any of the Community Legal Services' offices listed on this brochure.**

### Disability Advocacy Project

5060 N. 19th Avenue, Suite 306  
Phoenix, Arizona 85015  
(602) 212-2724 TTY: (602) 212-2702

### Volunteer Lawyers Program

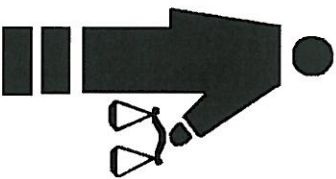
305 South Second Avenue  
Phoenix, Arizona 85003  
(602) 258-3434 1-800-852-9075 TTY: (602) 254-9852

### Eastside Office - Mesa

20 W. First Street, Suite 101  
Phoenix, Arizona 85201  
(480) 833-1442 1-800-896-3631 TTY: (480) 644-0572

### Yavapai County Office - Prescott

401 N. Mount Vernon  
Prescott, Arizona 86301  
(928) 445-9240 1-800-233-5114 Arizona Relay - 711



### Mohave County Office - Kingman

1720 Beverly, Suite A  
Kingman, Arizona 86401  
(928) 681-1177 1-800-255-9031 TTY: (928) 681-7281

### Yuma/La Paz Counties Office - Yuma

201 South 1st Avenue  
Yuma, Arizona 85364  
(928) 782-7511 1-800-424-7962 Arizona Relay - 711

### Farmworker Program - Main Office

305 South Second Avenue  
Phoenix, Arizona 85003  
(602) 258-3434 1-800-356-7115 TTY: (602) 254-9852

### Farmworker Program - San Luis Office

845 E. "B" Street, Suite 2  
San Luis, Arizona 85349  
(928) 627-8023 1-800-356-7115 Arizona Relay - 711

## COMMUNITY LEGAL SERVICES

# AHCCCS

## Arizona Health Care

## Cost Containment

## System



**YOUR RIGHTS TO MEDICAL SERVICES UNDER THE AHCCCS MANAGED CARE PROGRAM**

NOTE: This pamphlet contains legal information which is periodically updated by Community Legal Services. Call CLS to find out if this pamphlet has been updated since the printing date on the back cover.

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United Way Partner Agency



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## FREQUENTLY ASKED QUESTIONS

3. Your health plan may deny services because they are available to you from another source, such as a school or other state agency. This is not a good reason to deny services if they are medically necessary.

**W**hat if my Health Plan denies a new service or stops a service I am currently getting?

If the request for a new service is denied or a current service stopped, you and your doctor will receive a Notice of Action from your Health Plan explaining the reasons for the denial. If you disagree with your health plan's decision, you may file an appeal. The Notice of Action will explain your appeal rights.

If you are being denied a service that you are currently receiving (not a new service), you can request that the service be continued during the appeal process. To do this you must make the request in writing to the Health Plan within 10 days of receiving the Notice of Action. However, if your appeal is unsuccessful, the Health Plan may recover the cost of the services furnished to you.

### Filing Your Appeal

You can ask the Health Plan to review the decision by filing an appeal with the Health Plan within 60 days after the date of the Notice of Action. You can call the Health Plan to request an appeal, but it is best to file an appeal in writing. Your letter should explain the reason(s) you disagree with the Health Plan's decision. Keep a copy of your letter for your records. You should also attach any documentation that shows the service being requested is medically necessary, such as a letter from your doctor that explains why you need the service. You should receive a written Notice of Appeal Resolution within 30 days after the Health Plan receives your appeal.

If your appeal is denied, you can request a State Fair Hearing. You must request the hearing in writing and the Health Plan must receive it no later than 30 days after the date of the Notice of Appeal Resolution. You will receive a Notice of Hearing which will tell you the day, time and location of the hearing. You will be allowed to present documents and witnesses to prove the medical necessity of the service that your doctor is requesting. A judge will make a recommended decision to AHCCCS. The Director of AHCCCS will make a final decision.



**C**an I change my doctor or my health plan?

Yes. To change your doctor, call your Health Plan and get a list of doctors from which to choose. Once you choose a new doctor, the Health Plan staff will assist you in making the change.



You can change your Health Plan for any reason once a year in your AHCCCS anniversary month (the month during which you became eligible). In certain circumstances, AHCCCS may allow you to change your Health Plan even if it is not in your anniversary month.

**W**hat are "medically necessary" services?

Services or equipment are medically necessary if they prevent or treat diseases, disability, or other adverse health conditions, or prolong life. If a service or equipment is medically necessary for a child, it may be covered by AHCCCS even though it may not be covered for an adult.

**W**hy are some medical services denied and what can I do to assist my health plan in making a decision?

1. The health plan may deny a service that is not supported by proof that it is medically necessary. Make sure your doctor sends a letter to the Health Plan with the reasons the services are medically necessary. The letter should include a description of your medical condition and how the services/equipment will prevent or treat your condition. The letter should also explain what may happen if you do not get this service.

If the service is denied, you should have your doctor call and speak with the doctor at your Health Plan who made the decision. By doing so, your doctor may be able to convince your health plan to approve the service.



2. If your prescription is not covered on the Health Plan's drug list, called the drug formulary, it may be denied. Ask your doctor if there is another drug on the formulary that you can use. If you have used drugs on the formulary that didn't help you, ask your doctor to tell the Health Plan about these drugs and why they did not work for you.

AHCCCS is Arizona's Medicaid program, AHCCCS contracts with health plans and other program contractors to provide health care coverage to enrolled members.

Eligibility for AHCCCS is determined by various agencies. For example, pregnant women, adults and families generally apply for AHCCCS through the state's Department of Economic Security. Individuals who are elderly or disabled and receive Supplemental Security Income are deemed eligible through the Social Security Administration. Eligibility for programs like KidsCare, long term care and Medicare Cost Sharing is handled by AHCCCS itself. Each eligibility group has its own income and resource criteria.

When you are found eligible for AHCCCS, you are enrolled in the AHCCCS health plan of your choice such as Mercy Care or APIPA. Most "medically necessary" services are covered by the AHCCCS Health plans, including the following:

- ◆ Doctors office visits
- ◆ Specialist care
- ◆ Hospital services
- ◆ Pregnancy care
- ◆ Prescriptions and medical supplies
- ◆ Laboratory and x-ray services
- ◆ Transportation to and from doctor's appointments
- ◆ 24-hour emergency care
- ◆ Emergency dental care and medically necessary dentures
- ◆ Physical therapy

AHCCCS also covers mental health services. Available through the Regional Behavioral Health Authority (RBHA) in your area. Your health plan can tell you who to contact for information.

- ◆ Family planning services, but not abortion or abortion counseling
- ◆ Children under 21 also receive:
  - ◆ Shots and immunizations
  - ◆ Dental exams and treatment
  - ◆ Eye exams and glasses
  - ◆ Hearing tests and hearing aids
  - ◆ Nutritional information