WEST VIRGINIA INSURANCE COMMISSIONER
HEALTH PLAN ISSUER
ANNUAL GRIEVANCE REPORT

INSTRUCTIONS

W.Va. Code §114-96-3 states an issuer shall annually submit to the Commissioner, no later than March 31st, a report containing a compilation and analysis of the grievances filed, their disposition and their underlying causes. Please complete and return to ***Director of Health Policy, Office of the Insurance Commissioner, P.O. Box 50540, Charleston, WV 25305-0540, phone: (304) 558-6279 ext. 1120 or Health.Policy@wv.gov***

Health Plan Issuer Name: _____

Address: _____ Email: _____

City, State, Zip: _____

For questions, contact: (Name)_____(Phone Number)_____

Report for Calendar Year Ending: _____ Date Completed (MM/DD/YY): _____

FORMAL GRIEVANCES

I. Service Denied: Precert/ Non-Covered	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred External Review	Level of Review	# Remaining Open	Other (Explain)
Non-Covered												
Not Medically Necessary												
Out-of-Area Non-Par Provider												
Not Eligible For Service												
No PCP Referral												
Referral Denied												
Emergency Services Denied												
Mental Health Services Denied												
Access to Care												
Referral to External Review Organization												
Prescription Formulary												
Limitations on Prescription												
Other (State Reason):												

II. Payment: Post-Service	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open	Other (Explain)
Disputed Amount												
Coordination of Benefits Dispute												
Timeliness of Payment												
Balance Bill Dispute												
Non-Covered												
Not Medically Necessary												

II. Payment: Post-Service (Continued)	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open	Other (Explain)
Out-of-Area Non-Par Provider												
Member Not Eligible for Service												
No PCP Referral												
Referral Denied												
Emergency Services Denied												
Quality of Care Issues												
Mental Health Services Denied												
Prescription Formulary												
Limitation on Prescription												
Other (State Reason):												

III. Service: Administrative Related Grievances	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	Level of Review	# Remaining Open	Other (Explain)
Inability to access a member service representative and/or medical management staff by phone											
Members' handbooks and evidence of coverage not sent to the consumer within a reasonable period of time											
Identification cards not sent to the consumer within an appropriate period of time											
Misleading or outdated information noted in the Physicians' Directory											
Refusal to Insure											
Cancellation											
Nonrenewal											
Other (State Reason)											

Total Formal Grievances	Total	Expedited	Non Expedited	# Physician Initiated	# Enrollee Initiated	# Resolved in Favor of Grievant	# Resolved Against Grievant	With-drawn	# Referred to External Review	Level of Review	# Remaining Open

Turnaround Time (In Days)	Category I	Category II	Category III
Average			
Median			
Longest			
Shortest			