Address all written correspondence to:
HealthSmart
222 W. Las Colinas Blvd. #500N
Irving, TX 75039

If You Are Dissatisfied with HealthSmart or a Network Provider

If you should disagree with a decision made in the managed care process, you may submit in writing, describing the nature of your appeal and the action you request to HealthSmart. Your concerns must be submitted within thirty (30) days of the event giving rise to the issue. HealthSmart will expeditiously review your appeal and render a decision within thirty (30) days of receipt of your request. HealthSmart will maintain a record of the appeal for two (2) years as required.

You or your physician may initiate this process by completing the Employee Appeal Form (Appendix C).

The form should be submitted to:

HealthSmart
222 W. Las Colinas Blvd. #500N
Irving, TX 75039
304-556-1177 Fax

Prior to issuing a decision, HealthSmart may request additional information regarding a procedure, test, or surgery. Further, HealthSmart's Medical Director may need to consult with your treating physician directly to quickly resolve issues. All decisions will be made in compliance with accepted medical practice guidelines and with your best medical interests considered.

Your participation is important to the resolution of medical issues. Individuals reviewing your concern may need to speak directly with and receive input from you.

Please note, the appeal process is a prerequisite for the right to file a protest with the West Virginia Offices of the Insurance Commissioner, Office of the Judges. You have the right to file a protest with the West Virginia Offices of the Insurance Commissioner Office of Judges within 60 days of the protestable decision.

Identification and Verification

When you receive medical care in a hospital, clinic, or through an individual provider, you must identify yourself as a HealthSmart participant. To assist you, we provide an identification certification (see Appendix D). Just present this to the provider when you register.

If you need more information about your participation in HealthSmart, call 1.866-659-9315, 24/7 or contact your claim professional at 1-800-257-8134.

HealthSmart
Workers' Compensation Managed Care Plan

Employee Appeal Form

See HealthSmart Employee Manual for further information regarding filing a concern or issue. Or, if you wish to speak with someone concerning an appeal, call 1.866.659.9315 and ask to speak with the Coordinator.

An injured worker may use this form to submit an appeal about a concern with HealthSmart a specific medical issue, network medical provider, or any other problem that cannot be resolved by direct discussion with the appropriate parties.

Exemptions: The following items are specifically excluded from the appeal process: Indemnity Benefits; Vocational Benefits; Maximum Medical Improvement and Permanent Impairment; Medical Mileage Reimbursement; Provider Payments; Compensability. Concerns regarding any of the issues listed above should be directed to the employer or your claims representative.

This form is filed by:

Injured Worker's Name: _____

Claim number:_____ Date of Injury: _____

Social Security Number:_____

Primary Care/Treating Physician: _____

Physician Address: _____

Physician Office Telephone:_____

HealthSmart
Employee Appeal Form
Page 2

Injured Worker Name_____
Claim Number_____

If the space provided below is inadequate for you to fully explain your concern or the action you desire, continue your statement on a sheet of plain paper. Please be sure your name, social security number, and date of injury appear on each page of any attachment.

Please describe the nature of the issue or concern:

_____

_____

_____

_____

_____

_____

What action would you desire?

_____

_____

_____

_____

Has a concern been previously filed for this issue? ☐ Yes ☐ No

If Yes, date filed?_____

Form Completed by: _____
Injured Worker Signature

Date Form Completed: _____

Mail To: **HealthSmart**
222 W. Las Colinas Blvd. #500N
Irving, TX 75039
304-556-1177 Fax