West Virginia
Public Employees Insurance Agency
(/)

Manage My Benefits (https://openenrollment.wvpeia.com/YRE/)

How to Appeal a Medical Claim

If you are a PEIA PPB Plan participant or provider and think that an error has been made in processing your claim or reviewing a service, the first step is to call the Third Party Administrator to verify that a mistake has been made. All appeals must be initiated within 60 days of claim payment or denial.

Type of Error	Who to Call	Where to Write
Medical claim or case management	HealthSmart Benefit Solutions 1-888-440-7342	HealthSmart Benefit Solutions P.O. Box 366 Charleston, WV 25322
Out-of-state denial or denial of precertification	HealthSmart Care Management 1-888-440-7342	HealthSmart Care Management P.O. Box 1921 Charleston, WV25327-1921
Prescription drug claim	Express Scripts 1-877-256-4680	Express Scripts, Inc. ATTN: STD ACCTS P.O. Box 66583 St. Louis, MO 63166-6583

If your medical claim or service has been denied, or if you disagree with the determination made by one of the Third Party Administrators, the second step is to appeal in writing within 60 days of the denial to the Third Party Administrator at the address listed above. Explain what you think the problem is, and why you disagree with the decision. Please have your physician provide any additional relevant clinical information to support your request. The Third Party Administrator will respond to you by reprocessing the claim or sending you a letter.

If this does not resolve the issue, the third step is to appeal in writing to the director of the PEIA. The participant, provider or covered dependent must request a review in writing within sixty (60) days of getting the decision from the Third Party Administrator. Facts, issues, comments, letters, Explanations of Benefits (EOBs), and all pertinent information about the case should be included and mailed to:

Director, Public Employees Insurance Agency, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345

When your request for review arrives, the PEIA will reconsider the entire case, taking into account any additional materials which have been provided. A decision, in writing, explaining the reason for modifying or upholding the original disposition of the claim will be sent to the insured or his or her authorized representative. If additional information is required to render a decision, this information will be requested in writing. The additional information must be received within 60 days of the date of the letter. If the additional information is not received, the case will be closed.

External Review: If we have denied your request for the provision of or payment for a health care service or course of treatment, you may have a right to have our decision reviewed by independent health care professionals who have no association with us if our decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of care or effectiveness of the health care service or treatment you requested. Exercise this right by submitting a request for external review within 4 months after receipt of the notice of denial to the PEIA Clinical Unit, 601 57th Street, SE, Suite 2, Charleston, WV 25304-2345. For standard external review, a decision will be made within 45 days of receiving your request. If you have a medical condition that would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function if treatment is delayed, you may be entitled to request an expedited external review of our denial. If our denial to provide or pay for health care service or course of treatment is based on a determination that the service or treatment is experimental or investigational, you also may be entitled to file a request for external review of our denial.