



Your Future — Our Focus

## Chicago Regional Council of Carpenters Welfare Fund Instructions for Completing an Appeal Form – Retiree Plan of Benefits

- Determine if you have a claim for benefits.** Only a Participant, parent/guardian, patient, or Authorized Personal Representative has the right to appeal enrollment/eligibility for benefits or a claim for benefits that was denied in whole or in part. A claim for benefits must contain all of the following information: (a) patient's name (b) patient's date of birth, (c) Participant's name, (d) Participant's social security number or the identification number assigned by the Fund Office, (e) date of service, (f) name of the health care provider, (g) health care provider's tax identification number (h) address of health care provider, (i) procedure code and its corresponding meaning, (j) place of service, (k) the claim amount, and (l) a denial code and its corresponding meaning. A claim containing this information is called a "post service claim."

The Chicago Regional Council of Carpenters Welfare Fund does not require you to obtain prior approval (sometimes referred to as pre-authorization) for services or other medically necessary items prior to consideration of payment by the Fund (also known as a "pre-service" claim). A request (either verbally or in writing) by a provider or Participant to determine whether a certain procedure, prescription, or treatment is covered under the Plan (often referred to as a "pre-determination of benefits request") is **not considered a claim for benefits**; and therefore can not be appealed. A claim for benefits is one in which services have been rendered and the Fund has received a bill. Therefore, only a claim that has been **processed by the Fund Office and denied** (also known as a "post-service" claim), in whole or in part, can be appealed.

- Determine if you are filing a timely appeal.** If a post service claim has been denied, in whole or in part, the Participant, parent/guardian, patient or Authorized Personal Representative has no more than 180 days after you receive an adverse benefit determination to file an appeal.
- Complete the Appeal form in its entirety.** Print clearly in blue or black ink and answer all questions. If the form is not legible, if a question is left unanswered or if the form is not signed, it will be returned to you for completion. An Appeal form must be signed and dated to be valid.
- Attach additional information or evidence to the Appeal form.** You may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your appeal.
- Submit the completed Appeal form and any additional information to substantiate your appeal to:**

Scan & Email: pension@crccbenefts.org

Fax: Chicago Regional Council of Carpenters Welfare Fund  
Attn: Appeals Committee – Retiree Plan  
Fax Number: 312-951-3986  
(Note: Write the Participant's name and ID number on each page)

Mail: Chicago Regional Council of Carpenters Welfare Fund  
Attn: Appeals Committee – Retiree Plan  
12 East Erie Street, 8<sup>th</sup> floor  
Chicago, IL 60611

- What's happens next?** Within five (5) business days of the Plan's receipt of your request for an appeal, (1) the Plan will complete a preliminary review of the request to determine whether you have an appealable claim and (2) mail a letter to you acknowledging receipt of your appeal and informing you of the date of the next appeals meeting. Properly filed appeals are reviewed at the next regularly scheduled Appeals Meeting. The Appeals Committee meets at least quarterly. You will be notified of the Trustees' decision via first class mail, five (5) business days after making their determination.

**Note:**

- ✓ The appeal must be submitted in writing by the Participant, parent/guardian, patient or Authorized Personal Representative, within the applicable time frame. Copies of evidence supporting the appeal can be included.
- ✓ A covered individual may designate an Authorized Personal Representative by completing an Authorized Personal Representative Designation form and submitting it with the Appeal form.
- ✓ Providers or suppliers of service do not have appeal rights unless a covered individual designates the provider of service as his/her Authorized Personal Representative and the Fund Office receives a completed and signed Authorized Personal Representative Designation form or one must be on file with the Fund Office.



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### Chicago Regional Council of Carpenters Welfare Fund

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 4

FAX: 312-951-3986

### Appeal Form – Retiree Plan

**To: The Board of Trustees - Attn: Appeals Committee – Retiree Plan**

Participant's Name (the Carpenter)

Participant's ID # (located on your BCBS ID Card)

Participant's Street Address, City, State & Zip Code

Daytime Phone Number

Email Address

**I am requesting an appeal of:**

Enrollment or Eligibility for Benefits

Adverse Benefit Determination (complete the section below)

Claim Number(s) (on the Explanation of Benefits)

Date(s) of Service

Name of Provider(s)

Patient Name

Patient's Date of Birth

Patient's address (if same as Participant write same)

Name of Person Filing the Appeal

Daytime Phone Number

Email Address

I am the  Carpenter  Parent/Guardian  Patient  Authorized Personal Representative (if Authorized Personal Representative, the patient must complete an Authorized Personal Representative Designation form and include it with this form or one must be on file with the Fund Office.)

**State the reason(s) why you believe you should be allowed to enroll in the Plan or why you believe you should have eligibility for benefits or why you disagree with the adverse benefit determination:** (if more room is needed attach a sheet of paper)

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Check if you are including new or additional evidence (attach to form).

Signature of Participant, Parent/Guardian,  
Patient or Authorized Personal Representative

Date



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**Chicago Regional Council of Carpenters Welfare Fund  
Instructions for Completing an  
Authorized Personal Representative Designation Form**

- 1. Review the attached Policy for Recognition of an Authorized Personal Representative Statement.**
- 2. Complete the “Authorized Personal Representative Designation” form in its entirety.** Print clearly in blue or black ink and answer all questions. If the form is not legible, if a question is left unanswered or if the form is not signed it will be returned to you for completion. An Authorized Personal Representative Designation form must be signed and dated to be valid.
- 3. Submit the fully completed and signed “Authorized Personal Representative Designation” form to:**

Scan & Email:           pension@crccbenefts.org

Fax:                       Chicago Regional Council of Carpenters Welfare Fund  
Attn: HIPPA Privacy Officer – Retiree Plan of Benefits  
Fax Number: 312-951-3986

Mail:                      Chicago Regional Council of Carpenters Welfare Fund  
Attn: Retirement Benefits Department  
12 East Erie Street – 8<sup>th</sup> Floor  
Chicago, IL 60611

**Important Note:**

- ✓ Only the attached Authorized Personal Representative Designation form will be accepted by the Chicago Regional Council of Carpenters Welfare Fund. No other authorized personal representative designation forms will be accepted.
- ✓ The Plan will automatically recognize any person who holds a legal Healthcare Power of Attorney for an individual as that individual's personal representative.
- ✓ A Power of Attorney will not be accepted unless it specifically addresses decisions related to healthcare.
- ✓ It is important to understand that when you designate an individual to be your Authorized Representative, you are allowing that person or entity to have access to **all** of your protected health information (PHI). For example: If you only want your doctor to be able to act as your Authorized Representative to discuss a specific claim, then only list the specific claim number(s) or specific date(s) of service and/or diagnosis.



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### Chicago Regional Council of Carpenters Welfare Fund

12 EAST ERIE STREET • CHICAGO, IL 60611

(312) 787-9455, OPTION 4

FAX: 312-951-3986

## Authorized Personal Representative Designation Form Retiree Plan of Benefits

I, \_\_\_\_\_  
Name of Participant or Patient Participant's ID # (located on your BCBS ID Card)

\_\_\_\_\_  
Participant/Patient's Street Address, City, State & Zip Phone Number

hereby designate: \_\_\_\_\_  
Name of Authorized Personal Representative

\_\_\_\_\_  
Authorized Personal Representatives Street Address, City, State & Zip Phone Number

Relationship to Participant or Patient: \_\_\_\_\_ to act  
on my behalf or on behalf of: \_\_\_\_\_  
Name of Covered Individual(s)

\_\_\_\_\_  
Name of Covered Individual(s)

I authorize my Personal Representative to act for me [and for my covered spouse or dependent, if named above,] in receiving any information that is (or would be) provided to me as a participant/beneficiary of the plan, including but not limited to, any information that relates to my claim for coverage or benefits under the Plan and any individual rights that I have regarding my protected health information under HIPAA.

Or alternatively, I authorize my Personal Representative to act for me and for my covered spouse and dependents (if named above) in receiving **only** the following protected health information to **conduct the following functions** on my behalf: \_\_\_\_\_

I understand that this designation is subject to approval by the Plan. I also understand that, once approved, this designation will remain in effect unless I revoke it. I understand that I have the right to revoke this designation at any time by submitting a signed statement to that effect to the Fund Office.

I certify that I have reviewed the Plan's Policy for Recognition of Personal Representative (see attached).

\_\_\_\_\_  
Participant or Covered Individual's Signature Date

\_\_\_\_\_  
Authorized Personal Representative's Signature Date

# Chicago Regional Council of Carpenters Welfare Fund

## Recognition of Personal Representative Policy Statement

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This policy and procedure is adopted pursuant to Section 164.502 of the privacy rules under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and pursuant to section 2560.503-1 of the claims and appeals regulation under the Employee Retirement Income Security Act ("ERISA"). If the privacy rules are changed by HHS, we will follow the revised rules.

### RECOGNITION OF PERSONAL REPRESENTATIVE EFFECTIVE DATE

April 14, 2003

### RECOGNITION OF PERSONAL REPRESENTATIVE POLICY

1. The Plan will treat a personal representative as the individual for purposes of implementing the HIPAA privacy rules and ERISA's claims and appeals procedure rules.
  - a. The personal representative may only have access to PHI that is consistent with and relevant to the scope of authority set out in the personal representative form.

The Plan may elect not to treat a person as the personal representative of an individual if:

- (1) The Plan Administrator or the Privacy Official has a reasonable belief that:
    - (i) The individual has been or may be subjected to domestic violence, abuse, or neglect by such person; or
    - (ii) Treating such person as the personal representative could endanger the individual; and
  - (2) The Plan Administrator or the Privacy Official, in the exercise of professional judgment, decide that it is not in the best interest of the individual to treat the person as the individual's personal representative
2. The following individuals will be deemed to be a personal representative of an individual without having to complete a personal representative form, unless the Plan agrees to a request by an individual to restrict disclosure of PHI to the deemed personal representative under section 164.522 of the privacy regulation:
    - **SPOUSES:** The Plan will consider a spouse of a participant to be the personal representative of the participant. In addition, a participant will be deemed to be the personal representative of their spouse where the spouse is a beneficiary under the plan. Participants and beneficiaries should refer to the Plan's Privacy Notice for instructions on the Plan's procedure if they wish to restrict access of PHI to their spouse.
    - **ADULT CHILDREN:** The Plan will consider the parent or guardian, as defined in the Plan, of an adult child (18 or over) to be the personal representative of the adult child. Adult children should refer to the Plan's Privacy Notice if they wish to restrict access to their parents.
    - **UNEMANCIPATED MINORS:** The Plan will consider a parent or guardian, as defined in the Plan, as the personal representative of an unemancipated minor (17 or under) unless applicable law requires otherwise, or the Plan agrees to abide by a participant or beneficiary request that the Plan restrict disclosure of PHI to a parent or guardian.

- **DECEASED INDIVIDUALS:** The Plan will automatically recognize the following persons as personal representatives of deceased individuals or their estates:
    - a. Executors
    - b. Administrators
    - c. Other persons with authority to act on behalf of the deceased individual or their estate.
  - **TREATING PHYSICIAN REGARDING AN URGENT CLAIM:** In the case of an “urgent claim,” a “health care professional” (as these terms are defined in ERISA’s claims regulation) with knowledge of a participant or beneficiaries medical condition will be automatically recognized by the Plan as a personal representative. The health care professional is deemed to be a personal representative only with respect to the disclosure of PHI directly relating to the urgent claim.
  - **HEALTHCARE POWER OF ATTORNEY:** The Plan will automatically recognize any person who holds a legal healthcare power of attorney for an individual as that individual’s personal representative.
  - **OTHER APPLICABLE LAW:** The Plan will recognize any person who is authorized under State or other applicable law (e.g. court-appointed legal guardian) to act on behalf of the individual in making health care related decisions as that individual’s personal representative.
3. The Plan may disclose PHI to an individual who is not a personal representative (or deemed to be a personal representative) if they are a family member, other relative or close personal friend of the individual, or any other person identified by the individual, and the disclosure is directly relevant to such person’s involvement with the individual’s care or payment for the individual’s care pursuant to sections 164.510(b) of HIPAA’s privacy regulation. See the Plan’s Policy and Procedure for Uses and Disclosures for Involvement in an Individual’s Care and for Notification Purposes.
4. Where the Fund’s personal representative form has been completed and approved, it will be recognized by the Plan as long as the individual making the designation is covered by the Plan. No other authorized personal representative designation forms will be accepted. The individual has a right to revoke the designation at any time by submitting a signed statement to the Plan office revoking the designation. To designate another individual as personal representative, a new personal representative form must be completed and approved by the Plan.

## Chicago Regional Council of Carpenters Welfare Fund

### Recognition of Personal Representatives Procedures

Other than those individuals deemed to be personal representatives in paragraph 2 of the Policies related hereto, the Fund will only treat an individual as a personal representative where a personal representative form has been filled out and the Fund office has approved the designation. Only the attached Authorized Personal Representative Designation Form will be accepted. No other authorized personal representative designation forms will be accepted.

To download and print an authorized personal representative form, log on to the Fund’s website at [www.crcbbenefits.org](http://www.crcbbenefits.org). On the left hand side of the screen under “Health Plan” select “Forms.” Scroll down and print an Authorized Personal Representative Designation form. You may also request a copy of the personal representative form by calling the Fund Office at 312-787-9455, phone option 4. All personal representatives will be subject to the Fund’s verification procedure.



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## NONDISCRIMINATION STATEMENT

The Chicago Regional Council of Carpenters Welfare Fund (the “Plan”) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

The Plan provides language assistant services to persons whose primary language is not English, and free aids and services where necessary to people with disabilities to communicate effectively with us. If you need these services, contact the Fund Office.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Fund Office by mail, telephone or in person at: Chicago Regional Council of Carpenters Welfare Fund, Attn: Cindy Rivera, Civil Rights Coordinator, 12 E. Erie Street, Chicago, IL 60611, Phone: 312-787-9455.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD). Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

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**ATENCIÓN:** Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-312-787-9455.

**UWAGA:** Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 1-312-787-9455.

**注意:** 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-312-787-9455。

**주의:** 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-312-787-9455 (번으로 전화해 주십시오).

**PAUNAWA:** Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-312-787-9455.

**ملحوظة:** إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 1-312-9455-787)

**ВНИМАНИЕ:** Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-312-787-9455.

**સુચના:** જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-312-787-9455.

1-312-787-9455 خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں۔ کال کریں

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-312-787-9455.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 1-312-787-9455.

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-312-787-9455 पर कॉल करें।

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-312-787-9455.

ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε 1-312-787-9455.

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-312-787-9455.