HAVING TROUBLE ACCESSING ADDICTION TREATMENT BENEFITS THROUGH COMMERCIAL INSURANCE OR CHIP?

TELL US ABOUT IT – dasdbeck@hotmail.com
In the "subject" line, please put: Act 106

Commercial Insurance and Treatment for Addictions - (PA's Act 106 of 1989)

Act 106 of 1989 requires all commercial group health plans, HMOs and the Children's Health Insurance Program to provide comprehensive treatment for alcohol and other drug addictions.

The minimum benefits include:

(a) Up to 7 days detoxification per admission – 4 admissions per lifetime (hospital or non-hospital residential detoxification)

(b) Minimum of 30 days rehabilitation per year – 90 days per lifetime (non-hospital residential)

(c) Minimum of 30 sessions of outpatient/partial hospitalization per year – 120 sessions per lifetime (outpatient/partial hospitalization)

(d) Family counseling and intervention services

(e) Additional Treatment – Beyond the coverage described above, 30 additional outpatient/partial hospitalization sessions are provided which can be utilized on a two-to-one basis to provide 15 additional non-hospital, residential treatment days.

Act 106 of 1989 also specifies the method of accessing treatment.

> "Under the Act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment." *(PA Insurance Department, Drug and Alcohol Use and Dependency Coverage, Notice 2003-06)*

The provisions of Act 106 of 1989 have been upheld by the Pennsylvania Insurance Department and the Supreme Court of Pennsylvania.

This is not an emergency or crisis service. For emergencies, call your local county Crisis Hot Line or local Single County Authority on Drugs and Alcohol

NOTICES

Drug and Alcohol Use and Dependency Coverage; Notice 2003-06

[33 Pa.B. 4041]

This notice is issued to advise all entities subject to Act 106 of 1989 (act) (40 P. S. §§ 908-1--908-8) of their obligations under Commonwealth law in the provision of coverage for alcohol or other drug abuse and dependency benefits. The act requires specific coverage of drug and alcohol treatment services in certain group insurance policies or contracts. Drug and alcohol use and dependency are recognized in this Commonwealth as public health problems with serious workplace, health care, community and criminal justice ramifications. The Insurance Department (Department) releases the following guidance concerning the provision of benefits under the act.

The act specifies that all group policies, contracts and certificates subject to the act providing hospital or medical/surgical coverage shall include within that coverage certain benefits for alcohol or other drug abuse and dependency. Under the act, the only lawful prerequisite before an insured obtains nonhospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or licensed psychologist. It is the Department's determination that the same prerequisite applies for inpatient detoxification coverage. The certification and referral in all instances controls both the nature and duration of treatment. The location of treatment is subject to the insuring entity's requirements regarding the use of participating providers.

Act 68 of 1998 (40 P. S. §§ 991.2101--991.2193), governing quality health care accountability and protection, does not change the requirements under the act and should be read in conjunction with these existing requirements. Thus, an entity subject to Act 68 may utilize precertification or utilization reviews, provided, however, that the decision of the precertification or utilization review does not limit the act certification and referral by the licensed physician or licensed psychologist.

Questions regarding this notice should be addressed to Ronald A. Gallagher, Jr., P. E., Deputy Commissioner, Office of Consumer and Producer Services, Insurance Department, 13th Floor, Strawberry Square, Harrisburg, PA 17120, ra-in-Act106@state.pa.us.

M. DIANE KOKEN,
Insurance Commissioner

[Pa.B. Doc. No. 03-1566. Filed for public inspection August 8, 2003, 9:00 a.m.]

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DASPOP

NAME OF TREATMENT PROGRAM
ADDRESS, PHONE NUMBER

Name of Physician or Psychologist
LIC #

Name of patient: _____ Date of Birth: _____

Address: _____

Rx: I, _____ certify the above-named patient to:

_____ up to 7 days detoxification

_____ minimum of 30 days non-hospital residential

_____ minimum of 30 units of outpatient/partial

_____ additional outpatient or residential treatment through the additional treatment section of Act 106 of 1989

_____
Signature of Physician or Psychologist

Date: _____

Rev. 10/10

COMMONWEALTH OF PENNSYLVANIA

INSURANCE COMPLAINT FORM

(PLEASE TYPE OR PRINT)

In order for the Insurance Department to review your complaint, we ask you to complete this form and return it to the nearest regional office listed on the following page. It is our goal to assist you in resolving your complaint as quickly as possible. The more information and documentation you provide with this complaint form the better we will be able to assist you in a timely manner. You will receive an acknowledgement within a few days of our receipt of your complaint advising you of the name and telephone number of the investigator assigned to assist you and the file number of your case. In general, you can expect the investigator to contact you within thirty (30) days to advise you of our findings.

NAME: _____

ADDRESS: _____

_____

INSURED'S NAME: (IF OTHER THAN ABOVE) _____

INSURANCE CARD ID NUMBER: _____

DAYTIME TELEPHONE

HOME: (____) _____

WORK: (____) _____

1. Does this complaint involve an individual that is Medicare eligible? ☐ (Y/N)

2. Type of Insurance:
   - ☐ Auto
   - ☐ Homeowners
   - ☐ Renters/Condo
   - ☐ Commercial
   - ☐ Flood
   - ☐ Title
   - ☐ Individual Life
   - ☐ Group Life
   - ☐ Annuity
   - ☐ Viatical
   - ☐ Individual Health
   - ☐ Group Health
   - ☐ HMO
   - ☐ Medicaid
   - ☐ Medicare
   - ☐ Medicare Advantage
   - ☐ Medicare Supplement
   - ☐ Long Term Care

3. Type of Problem:
   - ☐ Cancellation/Nonrenewal
   - ☐ Sales Misrepresentation
   - ☐ Claim Handling
   - ☐ Other (specify) _____
   - ☐ Billing/Premium Dispute

4. (A) If your problem involves an insurance company, give the full name of the company:

   _____

   (B) If your problem involves an agent or broker, give his/her full name, address and phone number.

   _____

5. Policy Number: _____ In what State was this policy sold? _____

6. Date & location of loss: _____ Claim #: _____

7. Have you previously reported this problem to our office or any other agency? ☐ Yes ☐ No

8. Are you represented by an attorney? ☐ Yes ☐ No If yes, please give name, address and telephone #:

   _____

Note: If you have proceeded with litigation against the company and/or agent we will not be able to assist you until the litigation has been completed and the court has found misconduct on the part of these parties.

INSURANCE COMPLAINT CHECKLIST

DID YOU:

- ☐ Complete the Attorney General's Health Care Complaint Form?
  - ☐ Write L. Williams' name on the upper left side of the Complaint Form?
  - ☐ Specify the nature of the complaint?
  - ☐ Sign the Complaint Form?
  - ☐ Sign the Release Form?
  - ☐ Write cc: Deb Beck at the bottom of the Attorney General's Complaint Form?
- ☐ Complete the Insurance Department's Complaint Form?
- ☐ Include a copy of the Physician's Certification to Treat?
- ☐ Mail or fax all of the above to (1) Attorney General's Office, (2) PA Insurance Department, (3) Deb Beck and (4) health insurance plan of the subscriber?

Deb Beck/DASPOP
4075 Linglestown Road
P.O. Box 230
Harrisburg, PA 17112
717-657-7784 (Fax)

Linda Williams, Health Care Section
Office of the Attorney General
14th Floor, Strawberry Square
Harrisburg, PA 17120
717-787-1190 (Fax)

Carolyn Morris, Director
PA Insurance Department
Bureau of Consumer Protection
13th Floor, Strawberry Square
Harrisburg, PA 17120
717-787-8585 (Fax)

Health insurance plan of the subscriber
(not the Managed Care Organization)

DASPOP

NAME OF TREATMENT PROGRAM
ADDRESS, PHONE NUMBER

Name of Physician(s)
LIC #

_____

_____

Name of patient: _____ Age: _____

Address: _____

Date: _____

Rx: I, Dr. _____ certify the above-named patient to inpatient detoxification _____ days, inpatient rehabilitation services for _____ days and outpatient for _____sessions.

(Insert number of days certified for inpatient detoxification, inpatient rehabilitation and number of sessions for outpatient.)

_____MD/DO

DASPOP 4075 Linglestown Road Box 230, Hbg., PA 17112 717-657-7702 717-657-7784 (Fax)

SAMPLE LETTER TO INSURERS

Dear

We have admitted ___(Insert Name of Patient)_____ to treatment services prescribed by our physician.

Our decision to proceed with treatment is based on the following:

-- The treating physician, (Insert Name of Physician), has prescribed the treatment plan indicated above. I have attached (Insert the doctor's name) prescription to this letter.

-- Under Pennsylvania law, your authority to control the treatment of this patient does not withstand objection from the treating physician. I have attached the Policy Statement issued by the Insurance Commissioner of the PA Insurance Department. This document states that ***"Under the Act, the only lawful prerequisite before an insured obtains non-hospital residential and outpatient coverage for alcohol and drug dependency treatment is a certification and referral from a licensed physician or psychologist".*** See the attachment to this letter for the full text.

If you do not authorize treatment for the above-named patient, we will continue treatment and provide information of any denial to the Office of the Attorney General/Health Care Section, the Pennsylvania Insurance Department and the Drug and Alcohol Service Providers Organization of Pennsylvania.

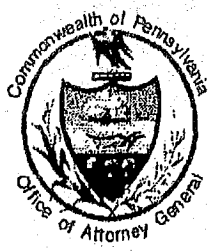
Thank you for your prompt attention to this matter.

Sincerely,

(Name/Position of Program Staff)

cc: DASPOP/P.O. Box 230 4075 Linglestown Rd., Harrisburg, PA 17112 717-657-7784 (Fax)
Linda Williams/Office of the Attorney General/Health Care Section, 16th Fl., Strawberry Square Harrisburg, PA 17120 717-787-1190 (Fax)
Carolyn Morris/PA Insurance Department/Bureau of Consumer Services, 13th Fl, Strawberry Square, Harrisburg, PA 17120 717-787-8585 (Fax)

PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL



HEALTH CARE COMPLAINT FORM

TOM CORBETT
ATTORNEY GENERAL

www.attorneygeneral.gov
1-877-888-4877

Health Care Section
14th Floor, Strawberry Square
Harrisburg, PA 17120
(717) 705-6938
Fax: (717) 787-1190

Office Use Only Investigator: Complaint #

YOUR NAME | HOME TELEPHONE #

ADDRESS | WORK TELEPHONE #

CITY | STATE | ZIP CODE | COUNTY

NAME OF PRIMARY BUSINESS COMPLAINT IS AGAINST | TELEPHONE

ADDRESS

CITY | STATE | ZIP CODE | COUNTY

(check those that apply)
☐ Cash ☐ Check
☐ Credit Card
☐ Other - Please specify:

Provider Information

Physician Name _____

Physician Address _____

Physician Phone _____

Hospital/Facility _____

Physician Name _____

Hospital Address _____

Hospital Phone _____

Health Insurance Information

Insurance Company _____

Insurance Company Phone _____

Policy No. _____

Group No. _____

Subscriber's Name _____

Patient's Name _____

Patient's Date of Birth _____

Patient's Relationship to Subscriber _____

Type of Insurance: ☐ Indemnity ☐ HMO ☐ PPO ☐ POS ☐ Traditional Medicare/Medical Assistance ☐ Other _____

Do you have insurance through your employer? ☐ Yes ☐ No
If yes, what is the name of your employer? _____

FILING A COMPLAINT WITH THE OFFICE OF ATTORNEY GENERAL DOES NOT PRESERVE YOUR APPEAL RIGHTS PURSUANT TO YOUR INSURANCE CONTRACT OR ANY APPLICABLE LAWS (I.E. ACT 68.) TO PRESERVE YOUR RIGHTS YOU MUST FILE AN APPEAL (COMPLAINT OR GRIEVANCE) DIRECTLY WITH YOUR HEALTH INSURER/ ADMINISTRATOR IN CONFORMANCE WITH THE TERMS OF YOUR COVERAGE.

Did you file a formal appeal (complaint or grievance) with your health plan? ☐ Yes ☐ No
If yes, what was the outcome of the appeal (complaint or grievance)?

_____

Has the matter been submitted to another agency? ☐ Yes ☐ No
If yes, please provide name and address _____

Has this matter gone to collections? ☐ Yes ☐ No
If yes, please provide name and address of collection agency _____

PROVIDE AND SIGN ATTACHED MEDICAL

Please explain your complaint. You may use additional sheets, if necessary. Please write or type clearly. Try to be brief, but be sure to tell **WHAT** happened, **WHEN** it happened, and **WHERE** it happened. Be specific about any oral statements the business made to you, including , if possible, the names of individuals you allege to have made the statements. Describe events in the order in which they happened. **ATTACH COPIES** of all applicable insurance contracts or policies, medical bills, explanations of benefits, correspondence, receipts, canceled checks (front & back), advertisements or any other papers that relate to your complaint. Please be sure all copies are **legible** and **labeled**. Be sure to sign and date the attached **"Authorization to Release Medical/Insurance Records."** We are unable to pursue your complaint if you fail to sign and date the "Authorization."

What specific resolution are you seeking in order to settle your complaint?

PLEASE READ CAREFULLY

The Attorney General cannot act as your private attorney. As a law enforcement agency, the primary function of the Office of Attorney General is to represent the public at large by enforcing laws including those prohibiting fraudulent, deceptive, confusing or misleading trade practices. Through the Health Care Section (HCS), the Attorney General does provide a service to consumers through his mediation unit, to resolve individual consumer complaints. The information you provide in this form will be used in an attempt to resolve your complaint and will be shared with the party(ies) against which the complaint is filed. Your complaint will remain on file with our Office and the information contained in it may be used to establish violations of Pennsylvania law.

By signing below:

1. I certify that the information provided in this complaint form, including my identity and any factual statements or allegations, are true and correct to the best of my knowledge, information and belief.

2. I understand that filing a complaint with the HCS does not preserve my appeal rights pursuant to Act 68, Medicare, or my insurance contract or policy.

3. I authorize the HCS to provide a copy of this complaint to any person or company about which I am complaining; and to any person or provider possessing medical and insurance records or information related to the complaint.

4. I authorize the HCS to transfer my complaint to another federal, state, local, or other agency which may have jurisdiction over this matter. This authorization extends to any or all attachments which may be part of my case file, including any medical records the Office may obtain pursuant to my medical release.

YOUR SIGNATURE

DATE

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

TOM CORBETT
ATTORNEY GENERAL

Authorization to Release Medical and Insurance Records

I hereby authorize any of the following: physician or medical practitioner; hospital or medical clinic or facility; insurance company; third party administrator; employer; debt collector; pharmacy; or other provider or person possessing any of the medical and insurance records for

_____

(individual's name, printed), to release the records and information, as described below, to:

Office of Attorney General
Health Care Section
14th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120
717.705.6938

These records should relate to the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Section in the investigation of my complaint.

I authorize the Office of Attorney General, Health Care Section, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local or other agencies as deemed appropriate.

I understand that: (1) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization; (2) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign such authorization; and (3) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by HIPAA.

This authorization expires upon the conclusion of the investigation into the complaint by the Office of Attorney General.

Signature of Individual or
Authorized Personal Representative _____

Description of Personal Representative's Authority _____

Individual's Social Security Number _____

Individual's Date of Birth _____

Date of Authorization _____

File No. _____
(For Office Use Only)

(Revised 09/05)

COMMONWEALTH OF PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL

TOM CORBETT
ATTORNEY GENERAL

Authorization to Release Medical and Insurance Records Related to Substance Abuse

I hereby authorize the following:

_____ *(physician or medical practitioner);*
_____ *(hospital or other clinical facility);*
_____ *(insurance company);* or

_____ *(third party administrator),*
possessing medical and insurance records for:

_____ *(individual's name, printed),*
to release the records and information, as described below, to:

Office of Attorney General
Health Care Section
14th Floor, Strawberry Square, Harrisburg, Pennsylvania 17120
717.705.6938

These records should relate to substance abuse treatment as identified in the complaint I, or my authorized representative, filed with the Office of Attorney General. The purpose of this authorization is to aid the Health Care Section in the investigation of my complaint.

I authorize the Office of Attorney General, Health Care Section, to disclose any information obtained pursuant to this Authorization, along with the other information contained in its case file, to such other federal, state, local or other agencies as deemed appropriate.

I understand that: (1) my substance abuse records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations; (2) I have the right, upon written notification to the Office of Attorney General, to revoke this authorization, except to the extent that action has been taken in reliance upon it; (3) under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), a covered entity may not condition treatment, payment, enrollment or eligibility for benefits if I refuse to sign such authorization; and (4) information disclosed pursuant to this authorization is subject to re-disclosure by the Office of Attorney General and will no longer be protected by HIPAA.

This authorization expires upon the conclusion of the investigation into the complaint by the Office of Attorney General.

Signature of Individual or
Authorized Personal Representative _____

Description of Personal Representative's Authority _____

Individual's Social Security Number _____

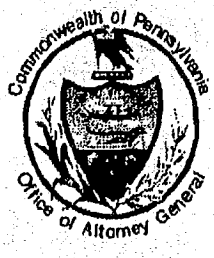
Individual's Date of Birth _____

Date of Authorization _____

File No. _____
(For Office Use Only)

(Revised 09/05)

PENNSYLVANIA
OFFICE OF ATTORNEY GENERAL



HEALTH CARE COMPLAINT FORM

TOM CORBETT
ATTORNEY GENERAL

www.attorneygeneral.gov

WHEN SHOULD YOU FILE A COMPLAINT?

If you are unable to resolve a health-related complaint directly with the person or company you are complaining against, **then** you should file a complaint with the Office of Attorney General, Health Care Section (HCS), by completing a complaint form and medical release authorization. If your complaint is against your insurance company, then you should refer to your contract to ensure that you have taken all the appropriate steps to file a complaint or grievance directly with the Plan. **Filing a complaint with the HCS does not preserve your appeal rights; therefore, you are encouraged to file an appeal with your insurance company while simultaneously filing a complaint with the HCS.**

The completed forms and any supporting documentation should be mailed to the address below or you may file your complaint online at www.attorneygeneral.gov/complaints.aspx?id=458.

Office of Attorney General
Health Care Section
14th Floor, Strawberry Square
Harrisburg, PA 17120

HOW CAN YOU EXPEDITE THE PROCESSING OF YOUR COMPLAINT?

- Complete all portions of the complaint form that apply to your situation
- Describe what actions you have taken to resolve your complaint
- State what action you are seeking in order to resolve your complaint
- Include any supporting documentation that further explains your complaint and your position for resolving the complaint

WHAT SHOULD YOU EXPECT AFTER YOU FILE A COMPLAINT?

Your complaint will be reviewed to determine if the HCS is the most appropriate agency to address your concerns. Upon receipt of your complaint, the HCS will send you an acknowledgment letter:

1. Providing your file number and assigned Agent; or
2. Advising that your complaint has been forwarded to another state or federal agency for handling.

If your complaint is assigned to an Agent, then **your Agent will forward a copy of your complaint (as submitted) to the person or company you are complaining against** and request a response to the complaint within 15 business days. Your Agent will forward you a copy of the response to your complaint and will keep you informed of any new developments in your case. Please allow your Agent a minimum of 30 days to contact you with an update on your file.

Family Advocacy for Addiction Treatment

Mission Statement

Although addiction treatment resources are widely available in Pennsylvania, access can be difficul complicated, cumbersome and sometimes life endangering. Families and clients currently lack advc addressing the cost and difficulties of accessing healthcare coverage. Family Advocacy for Addictic Treatment seeks to remedy the problem of needless barriers to existing treatment resources.

Is drug or alcohol addiction affecting you or a family member?
Are cost issues a barrier to treatment?
Has your insurance company denied benefits for treatment?
No insurance – and you don't know where to turn for help?

ACCESS FAMILY ADVOCACY FOR ADDICTION TREATMENT
can assist you with overcoming the cost barriers to drug and alcohol treatment.

KNOW YOUR INSURANCE RIGHTS!

PA Act 106 of 1989 requires most group health insurance plans to cover drug & alcohol addiction treatment. The minimum mandated coverage includes:

- Up to 7 days detox per admission – 4 admissions per lifetime
- Minimum of 30 days rehab per year – 90 days per lifetime/non-hospital

DID YOU KNOW...

Addiction treatment, when ta the needs of the individual, effective as treatments for o illnesses such as diabetes, hypertension and asthma.

residential)

- Minimum 30 units of outpatient treatment per year – 120 units per lifetime
- Plus 15 additional rehab days (inpatient) or 30 days additional outpatient units – or a combination (1 inpatient day = 2 outpatient units.)

[illegible] physician or psychologist.

About 92,000 Pennsylvanian treatment for alcohol and dr addictions during fiscal year However, the Department of estimates that over 941,500 of our state are in need of th

LET US HELP YOU

Access to quality treatment can be difficult. Those suffering from addiction often lack the support a advocacy needed to assist in addressing funding barriers to treatment.

ACCESS FAMILY ADVOCACY FOR ADDICTION TREATMENT seeks to help by:

- Educating those suffering from addiction about the resources available and their rights to treatment as legislat Pennsylvania.
- Interpreting healthcare plans for clients and families.
- Assisting with the appeal process when funding for treatment is denied.
- Assisting in obtaining timely admissions to treatment by consulting with funding sources and appropriate treatr facilities.
- Assisting families in recognizing their own needs for supportive services.

Call our toll-free number 1-866-709-0590 or email support@access-treatment.org

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