State of Arkansas Appeals Request Process

Arkansas State fully insured plan members, authorized representatives and prescribers are eligible to seek an exception and file an Appeal on a prior authorization that has been denied.

How to file an appeal?

- An appeal must be submitted within 180 days of receipt of denial letter. Appeal requests can be mailed or faxed to the contact information that is on the denial letter.

Who may file an appeal?

- Appeals can be submitted by the member, their prescriber, or a relative, friend, advocate, or anyone else (including an attorney) who can act on the member's behalf as an authorized representative.

How long will it take to review an appeal?

- If the request is non-urgent, the appeal will be reviewed, and a decision will be made no later than:
    - 15 days after a request is received if the member's plan has two levels of internal appeal
    - 30 days after a request is received if the member's plan has only one level of internal appeal
    - 72 hours after receipt of complete information if it is a step therapy appeal request
- If the request is urgent, the appeal will be reviewed, and a decision will be made no later than:
    - 72 hours after a request is received if the member's plan has one or two levels of internal appeal
    - 24 hours after receipt of complete information if it is a step therapy appeal request
- Members and prescribers will receive a letter that responds to their appeal and explains the decision.

What happens after an Appeal?

- If an appeal is denied, a member or prescriber have a right to ask for an external review of the claim by an independent third party, who will review the denial and issue a final decision.
- A member or prescriber may have the right to request an expedited external review at the same time as their Appeal.

To fulfill requirements of Ark. Code Regs. § 23-92-512
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