services that were provided out-of-country. In these situations, claims may be submitted up to 24 months after the date of service.

It's also important to remember that when filing a claim, you should make sure to include all necessary documentation. This includes itemized bills, a completed claim form, and any other documentation that is requested by Northwind Health. If any of these items are missing, your claim may be delayed or denied.

To ensure timely filing, it's important to keep track of the dates of service for all services you receive. You should also keep copies of all documentation related to your services, and if you're unsure of the filing requirements, you should contact Northwind Health for clarification.

Overall, timely filing is an important part of the claim filing process. By following the guidelines for timely filing and including all necessary documentation with your claims, you can help ensure that your claims are processed quickly and accurately.

COMPLAINTS AND APPEALS

What You Can Appeal

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When you have Northwind Standard coverage, you have the right to appeal any denial of services or payment of benefits. This includes if you disagree with the amount of the payment or if you feel that your claim was denied incorrectly. You also have the right to appeal if you feel that an authorization was not provided for a service, or if you believe that a service should be covered by your plan but was not.

If you believe that your claim was wrongly denied or that you have a dispute over a service that is covered or not covered, you have the right to file a formal appeal. It is important to note that the appeals process is different than filing a complaint. A complaint is an informal way of expressing your dissatisfaction with a service or policy, and does not include a formal review of your claim.

You can file an appeal by submitting a letter or appeal form to Northwind Health. The letter or form should include the reason for your appeal, supporting documentation, and any other information that you believe will be relevant to your case. It is important to note that you must file your appeal within 60 days of the date of the denial, or within 180 days if the denial is related to a service that was preauthorized by your insurance provider.

When you file your appeal, Northwind Health will review it and provide you with a written decision. This decision will include an explanation of why your claim was denied or why a service was not covered. It is important to note that all appeals will be reviewed according to the terms of your plan and in relation to any applicable state or federal laws.