



UnitedHealth Group®

9  
1  
0  
2  
1  
0  
8  
3  
1  
8  
4  
6  
5

THIS DOCUMENT WAS RECEIVED IN

APPEAL PO BOX 30573 or FAX 801-938-2109, SLC, UT-RMO WEST

FAX

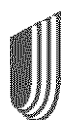
03/24/2021

1501

**United Health Group - West, Central and Cirrus RMO**

Operated by Firstsource Solutions

1355 South 4700 West  
Salt Lake City, UT 84104



UnitedHealthcare®  
A UnitedHealth Group Company

**RECEIVED  
VIA  
FAX/FTP**

**BEST COPY AVAILABLE**

**DO NOT Return to the RMO for  
Rescan**

9  
1  
0  
2  
1  
0  
8  
3  
1  
8  
4  
6  
5



## Designation of Authorized Representative

Member Name ( <i>please print</i> )	Date of Birth	Member ID number	
Shay M Sheppard	10/10/1970	871386343	
Member's Street Address	City	State	Phone
3626 E Coronado Rd	Phoenix	AZ	(602) 576-1486
Name of Individual/Company/Law Firm being designated as the authorized representative			
Advanced Reimbursement Solutions / ARS			
Designated Representative's Address	City	State	Phone
2801 Centerville Rd 1st Floor, PMB 550	Wilmington	DE	(302) 316-5305
Provider of Service			
THS Tech IOM, LLC			
Date(s) of Service or Proposed Service			
05/02/2020			

I, Shay M Sheppard do hereby name

*Print the name of the member who is receiving the service or supply*

Advanced Reimbursement Solutions / ARS

*Print the name of the person who is being authorized to act on the member's behalf*

to act as my authorized representative in requesting (*check all that apply*)



a complaint



an appeal



documents

from UnitedHealthcare regarding the above-noted service or proposed service.

### I understand and agree that:

- This authorization is voluntary;
- my health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I may not be denied treatment, payment for health care services, or enrollment or eligibility for health care benefits if I do not sign this form;
- my health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulation;
- this authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying UnitedHealthcare in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Signature of Member	Date
Shay M Sheppard <i>ARS</i> Limited Power of Attorney	03/24/2021
If person signing this authorization is not the member, describe relationship to the Member (i.e. Parent, Legal Representative)	
Legal Representative - see attached POA	

Legal Representatives signing this authorization on behalf of a member must furnish a copy of a health care power of attorney, or other relevant document that grants the applicable legal authority



**ADVANCED REIMBURSEMENT SOLUTIONS**

2801 Centerville Rd., First Floor  
PMB #550  
Wilmington, Delaware 19808  
Phone: 302-316-5305

**Member Appeal**

March 24, 2021

# Cover Letter

---

**To: UHC**

Attention: APPEALS DEPARTMENT  
Address: PO Box 740800 Atlanta GA 30374-0800

**From: Advanced Reimbursement Solutions**

**Regarding:**

Beneficiary Name: Shay M Sheppard  
Date of Service: 2020-05-02  
Subscriber ID#: 871386343  
Group #:715014  
Claim #:CE86166023  
Opportunity Name: TTI-SHES050220IOM  
Provider: THS Tech IOM, LLC

TIN #: 83-2118184  
NPI #: 1467927004

**Advanced Reimbursement Solutions, LLC ("ARS") is formally requesting this claim to be opened for negotiations. Please fax your proposal to (310) 494-5929.**

Good Afternoon,

Attached is an appeal request due to a low reimbursement rate. The total billed charges were \$142,400.00 but we were paid \$0.00 of the claim. Included in this packet is the Power of Attorney/ Authorization of Representation stating we are the authorized representative to file appeals on behalf of the member.

Please process accordingly, if you have any questions, please feel free to contact our office at the phone or fax number provided.

Thank you.

IMPORTANT NOTICE – This message is intended solely for the use of the individual(s) or entity to which it is addressed and may contain information that is PRIVILEGED, CONFIDENTIAL, AND EXEMPT FROM DISCLOSURE UNDER APPLICABLE LAW. If you received this message in error, you are hereby notified we do not consent to any reading, dissemination, distribution or copying of this message. Please notify the sender and immediately destroy the transmitted information.

## AUTHORIZATION OF REPRESENTATION AND SPECIFIC POWER OF ATTORNEY Relating to Healthcare Benefits

### I. IDENTIFYING INFORMATION

Patient Name: Shay Sheppard Patient Date of Birth: 10/10/70  
 Insurance Carrier: UHC Member ID: 871386343  
 Group #: 715014 Subscriber ID or S.S. #: \_\_\_\_\_  
 Primary Subscriber Name: Shay Sheppard Primary Subscriber Date of Birth: 10/10/70  
 Primary Subscriber Employer: NATIONWIDE INSURANCE  
(If insurance plan is not through employer, write "self")  
 Primary Subscriber Employer Address: 9200 E. PIMA CENTER BLVD PHOENIX AZ 85258  
(Street) (City) (State) (Zip)

### II. AUTHORIZATION OF REPRESENTATION

I, Shay Sheppard hereby appoint Advanced Reimbursement Solutions, L.L.C. (ARS) and/or Gregory B. Maxon Maldonado, President of ARS (collectively known as my "Authorized Representative") to act on my behalf, as my Authorized Representative, as permitted under Department of Labor Regulation Section 2560.503-1, in connection with the processing of claims, communicating with the Plan Administrator and/or Fiduciary, and/or appeals relating to services and/or products that I received from my Surgery Center, Physician, Medical Group, Durable Medical Equipment Provider and/or any other medical expenses (collectively known as "Services/Products") I have incurred within two (2) years prior to and after the date of the execution of this authorization.

I authorize my Authorized Representative to: (a) to communicate with me through email and/or text message regarding any and all matters related to scheduling my healthcare Services/Products and any and all matters related to billing for my healthcare Services/Products to the email and phone number on file; (b) to submit claims for my healthcare Services/Products to insurance companies, health plans, my employer-sponsored health plan's plan administrator, trust, self-funded plans, third party administrators, re-pricing companies, federal and state payers, and all other types of governmental and commercial payers on my behalf; (c) to pursue appeals of denials or underpayments of claims at all administrative levels, including (but not limited to) informal, internal and external appeals or reviews; (d) to request and receive documentation and information necessary to pursue collection of such claims; (e) to pursue any and all legal action and all legal remedies to which I am entitled regarding such claims including (but not limited to) recovering any underpayments or denials of payments, including claims for interests, penalties, breach of fiduciary duty, and punitive damages; (f) to resolve or settle any claims on my behalf; (g) to receive payments from all governmental and commercial payers on my behalf, and; (h) to retain an attorney to represent my Authorized Representative.

In furtherance of my Authorized Representative pursuing health benefit claims and appeals on my behalf, and any other administrative remedies to which I am entitled, under both state and Federal laws; I authorize my Authorized Representative to receive all information, from any source, to pursue such claims, appeals, and legal actions. Additionally, I authorize the hiring of an attorney, at ARS's cost, as necessary to pursue benefit claims, appeals of adverse benefit determinations and any applicable legal actions on my behalf. I authorize a copy of all information, correspondence and notifications, including but not limited to Explanations of Benefits, claim denials and approvals, and appeal denials and approvals relating to the Services/Products to be sent to Advanced Reimbursement Solutions, L.L.C., 2801 Centerville Road, First Floor, PMB #550, Wilmington, DE 19808.

This Authorization of Representation is effective as of the date signed below and will expire after claims within the Service Period are fully adjudicated or litigated as permitted under state and federal law. I understand that sometimes I may go to the same provider multiple times. This Authorization and Specific

smg Initial This is a legal document

AOR/POA 11.15.2017

Power of Attorney may be used and relied upon repeatedly and universally until its expiration. I understand that I may revoke this Authorization or the Specific Power of Attorney at any time by informing my Authorized Representative in writing. All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization will be communicated by me in writing.

If any insurance company, health plan, trust, self-funded plan, third party administrator, re-pricing company, federal and state payer, or governmental or commercial payer requires a specific form be filled out to appoint an authorized representative or any other forms related to Protected Health Information, please forward those forms, along with any plan language requiring I use such forms to ARS. The signing of this Authorization of Representation and Specific Power of Attorney evidences my intent to appoint ARS and/or Gregory B. Maxon Maldonado as my authorized representative and my attorney-in-fact.

I understand I have a duty to cooperate with ARS or its retained counsel in the processing of claims, appeals and interactions with my employer, if necessary. Revocation of any of the forms necessary to fully and properly adjudicate a claim may result in all outstanding balances being owed by the beneficiary. A price list of all services billed is available upon written request.

### **III. SPECIFIC POWER OF ATTORNEY**

This specific power of attorney is effective as the date below and will continue to be effective two years from date entered below or when the claim is paid in its entirety, whichever is first. Any third party who receives a copy of this document shall unequivocally accept instructions from my attorney-in-fact as if given directly by me.

To the extent any dispute arises between Authorized Representative, the Third Party Administrator (TPA), the health insurance carrier, and/or my Plan and/or its fiduciaries relating to a Benefit Claim or the manner in which similar claims will be treated by the TPA, including Plan Administrator and/or its fiduciaries now or in the future, it is my intention that the Plan and/or its fiduciaries give Advanced Reimbursement Solutions L.L.C. on my behalf any and all claims, rights, appeals and causes of actions that I could bring pursuant to Employment Retirement Income Security Act (ERISA) and the Patient Protection and Affordable Care Act (PPACA). This SPECIFIC POWER OF ATTORNEY grants the following:

- Ability for ARS, or its agents or representatives to sign, endorse and complete on my behalf any settlement agreements, releases, checks, and/or other documents necessary to properly and completely execute any Authorization of Representation and/or Protected Health Information (PHI) forms and any and all corresponding claims.
- To claim on my behalf any benefits, reimbursements, damages, excise taxes and awards
- Directly communicate with the Plan Administrator of my employer.
- Direct the Third-Party Administrator to mail checks directly to ARS for processing
- To edit, complete, and/or fill out any Insurance carrier forms necessary to adjudicate the claim, appeal the claim, or interact with my employer or Insurance carrier

### **IV ACKNOWLEDGMENTS**

By signing this form, I understand that I have been given an opportunity to have an attorney or other advisor review the documents and am knowingly waiving my right to have an attorney or other advisor review the documents. I further agree that a photocopy of this agreement shall be as effective and valid as the original. I also certify that I have read and understand the above statements and that all of my questions have been satisfactory answered.

I understand that if I would like additional time to have an advisor or an attorney review these forms, I have the option to reschedule the procedure(s) or set-up and at my own cost have all documents reviewed and explained to me by my attorney or advisor.

gm8

Initial This is a legal document

AOR/POA 11.15.2017

Additionally, I understand that I have a continuous and ongoing duty to timely cooperate with ARS during the processing of my claim and all subsequent appeals. Failure to cooperate with ARS may result in the insurance company fully or partially denying payment of the claim. If a full or partial denial of the claim occurs because I fail to cooperate, I understand that I may be responsible for the full payment of the claim

This Authorization of Representation and Specific Power of Attorney is effective as of the date signed below and will continue to be effective until claims relating to the Services/Products are paid in their entirety or for two years whichever comes first.

All correspondence and communications relating to the Services/Products should be directed to my Authorized Representative. Any change in my intent relative to this Authorization or Power of Attorney will be communicated by me in writing.

*Sharon Sherrill*  
Signature of Beneficiary/Participant

5/2/20  
Date

*K DeBord*  
Witness

5/2/20  
Date

By signing below, Advanced Reimbursement Solutions, L.L.C. and/or Gregory B. Maxon Maldonado hereby accepts the appointment to serve as Authorized Representative and Specific Power of Attorney as described above.

By: *Gregory B. Maxon Maldonado*  
Gregory B. Maxon Maldonado  
(602) 773-1478

DO NOT ALTER



2801 Centerville Rd., First Floor  
PMB#550  
Wilmington, Delaware 19808  
(302) 316-5305

VIA U.S.P.S. FIRM MAIL  
PER POSTAL SERVICE FORM 3877

'03/24/2021'

ATTN: Appeals Department  
PO Box 740800 Atlanta GA 30374-0800

**First Formal Appeal**

**Appealing for Insufficient Payment**

**Claim was not adjudicated according to beneficiary's health plan**

**Binding Instructions from a Legally Appointed Authorized Representative**

**"NOTICE" of PPACA/ERISA Violations of UHC's**

**Fiduciary Responsibilities to Shay M Sheppard.**

**Appealing for Insufficient Payment**

RE: Beneficiary Name: Shay M Sheppard  
Subscriber ID#: 871386343  
Date of Service: 05/02/2020  
Claim (s) Amount: \$142,400.00

Dear Sir or Madam:

Advanced Reimbursement Solutions, LLC ("ARS") has been appointed by Shay M Sheppard as her/his Authorized Representative (the "AOR") for (Subscriber ID: 871386343) Shay M Sheppard's medical claim and appeals processing, as indicated by the enclosed "Authorization of Representation" (the "Authorization") document. To date, the total amount paid on this claim is \$0.00.



This appointment has been made by Shay M Sheppard because Shay M Sheppard does not have the expertise to completely understand, navigate or determine the exact healthcare benefits to which Shay M Sheppard is entitled.

### **INITIAL CLAIM SUBMISSION FACTS**

**FACT:** On '08/24/2020', ARS, on behalf of Shay M Sheppard, submitted a clean medical claim to UHC and requested Shay M Sheppard's applicable plan documents.

**FACT:** On '09/24/2020', approximately 31 days after the claim was submitted, UHC sent its adverse benefit determination. UHC's notification violated multiple provisions of the Employee Retirement Income Security Act ("ERISA"), as explained below.

UHC sent an Explanation of Benefits (the "EOB") that indicated, among other things, that: (1) UHC required additional information to verify that medical services are eligible for coverage under the plan and requested substantiating documentation or treatment plan from the ordering physician; (2) the charges for this medical claim exceeded the maximum allowed amount; (3) the member's plan excluded coverage for charges that are experimental or investigational, according to professional standards of safety and effectiveness for diagnosis, care, or treatment; (4) the rendered medical services were performed within the period of another service and, as a result, were not covered; (5) the services rendered to the member were not medically necessary and were not required pursuant to accepted standards of medical practice; and (6) the charges associated with the medical services rendered to the member were not reasonable or appropriate. UHC's EOB does not meet the standards set forth by ERISA. The EOB fails to specifically state what additional information, "substantiating documentation," or "treatment plan" that UHC is requesting to adjudicate the claim.

Pursuant to ERISA mandates, ARS submitted a clean medical claim to UHC that included every document needed for UHC to properly adjudicate Shay M Sheppard's medical claim. Shay M Sheppard's physician determined that the medical services were necessary. ARS believes that UHC's unsubstantiated determination that the medical services were unnecessary, unreasonable, or inappropriate is actually an internal policy to delay or avoid proper adjudication of Shay M Sheppard's medical claim. UHC's practice creates unnecessary debt for the member and is detrimental to UHC's customer, UHC's practice is also in violation of ERISA and likely does not comply with the provisions of Shay M Sheppard's applicable plan documents. UHC has a fiduciary duty to process Shay M Sheppard's medical claim according to Nationwide Insurance's current Master and Summary Plan Documents. ARS has requested Shay M Sheppard's applicable plan documents on multiple occasions. To date, UHC, contrary to ERISA mandates, current case law and fiduciary principles, has failed to furnish ARS with the requested documents.

ERISA provides a reasonable opportunity for the member and authorized representative to conduct a full and fair review of an adverse benefit determination for a medical claim. *See* Claims Procedure, 29 CFR 2560.503-1(h)(2). Pursuant to this ERISA provision, ARS demands that UHC provide the following:

- (1) reference specific provisions of Shay M Sheppard's plan documents and any additional documents that define what medical services constitute experimental, investigational, or "medically necessary" services, and provide substantiating documentation as to what standards UHC is referring to, as well as an explanation as to how these standards apply to this claim and UHC's subsequent denial of this medical claim;
- (2) provide all documents and methodologies that UHC used in its calculation of the "allowed amount," and reference the specific provisions of Shay M Sheppard's plan documents that support these calculations;

- (3) If the allowed amount was based upon Maximum Non-Network Reimbursement Program ("MNRP") or a derivative thereof, such as Webstrat or Berges, reference the specific page in Shay M Sheppard's plan documents that allow for the use of MNRP. MNRP is a repricing tool used by Medicare or Retiree Plans to lower the out-of-pocket costs of the member. MNRP was never intended to be a tool for third-party administrators to underpay medical claims;
- (4) provide a copy of UHC's Administrative Service Agreement (the "ASA") with Nationwide Insurance and reference the provisions of the ASA that provide for the discretion to re-price of out-of-network claims;
- (5) provide all substantiating documentation that define what constitutes a "global period," and all documentation that explain the denial of payment for the medical services rendered to Shay M Sheppard;
- (6) reference the specific provisions of Shay M Sheppard's plan documents that define what constitutes "reasonable and appropriate charges," and explain the methodologies used by UHC to calculate the charges for medical services rendered to Shay M Sheppard.

UHC has violated the Patient Protection and Affordable Care Act ("PPACA") and *ERISA* by having inadequate claims procedures. If UHC continues to violate the healthcare claims procedures mandated by *ERISA* and the PPACA, the plan or Nationwide Insurance may be required to submit IRS Form 8928 (Return of Certain Excise Taxes under Chapter 43) to satisfy the excise tax penalty under 26 U.S.C. § 4980D. Section 4980D of the Internal Revenue Code imposes an excise tax of **\$100 per day per plan participant** for failure to comply with various group health plan mandates, including the requirements of Section 2719 of the Public Health Service Act ("PHSA"). *See* 29 U.S.C. § 1132(c)(1)(B). For example, a plan with 300 participants may be required to pay a daily excise tax of \$30,000 per day for each day that the plan is in violation. A plan subject to this excise tax must self-report the failure on IRS Form 8928, and penalties and interest may apply to late filings. Additionally, a plan's willful failure to provide a copy of the Summary of Benefits and Coverage (SBC) triggers a **\$1,000 penalty for each failure**.

When ARS submitted Shay M Sheppard's medical claim, ARS provided UHC with all necessary supporting documents to properly adjudicate and pay Shay M Sheppard's medical claim including, but not limited to, the Operative Report, the claim form, and a copy of the AOR and PHI forms.

#### **IS HEREBY PUT ON NOTICE FOR VIOLATING ONE OR MORE OF THE FOLLOWING ERISA/PPACA REQUIREMENTS:**

##### **Time Violations**

1. Claimant did not receive notification of determination within thirty (30) days (29 CFR §2560.503-1(f)(2)(iii)(B));
2. Claimant did not receive a request to extend claim processing for an additional fifteen (15) days that provided a required statement of necessity for the extension showing the delay was "due to matters beyond the plan's control" (29 CFR §2560.503-1(f)(2)(iii)(B)); and/or,
3. Claimant was not allowed forty-five (45) days from receipt of any such notice to correct the claim (29 CFR §2560.503-1(f)(2)(iii)(B)).

##### **Claim Determination (EOB) Violations**

4. The EOB did not specify specific reason(s) for denial (29 CFR §2560.503-1(g)(1)(i));
5. The EOB did not reference specific plan provisions upon which any determination was based (29 CFR §2560.503-1(g)(1)(ii));

6. The EOB did not reference additional material necessary for the Claimant to perfect the claim (29 CFR §2560.503-1(g)(1)(iii));
7. The EOB did not provide description of the review procedures, including a statement of rights under ERISA to bring a civil action (29 CFR §2560.503-1(g)(1)(iv));
8. The EOB did not comply with the following requirement: "If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a *statement* that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request" (29 CFR §2560.503-1(g)(1)(v)(A) (emphasis added)); and/or,
9. The EOB did not comply with the following requirement: "If the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an *explanation* of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant's medical circumstances, or a *statement* that such explanation will be provided free of charge upon request" (29 CFR § 2560.503-1 (g)(1)(v)(B) (emphasis added)).

### REQUEST FOR INFORMATION

Pursuant to 29 CFR 2590.715-2719(b)(2)(ii)(C) and 29 CFR 2560.503-1(g) and (h), ARS, as the authorized representative for Shay M Sheppard, hereby demands that UHC provide a copy of the member's entire claims file and all additional information used to process the claim(s) including, but not limited to, the following:

1. A copy of Shay M Sheppard's Summary of Benefits and Coverage (SBC) in effect during the date(s) of service and any updates to the SBC and Summary of Material Modifications (SMMs);
2. Copies of the particular section of the plan documents relied upon to make the adverse benefit determination;
3. The specific reason or reasons for the adverse benefit determination;
4. A copy of the specific plan provisions upon which the adverse benefit determination is based;
5. A description of any additional material or information necessary for Shay M Sheppard to perfect the claim and an explanation of why such material or information is necessary;
6. A description of the plan's review procedures and the time limits applicable to such procedures;
7. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse benefit determination, then UHC must provide that specific rule, guideline, protocol, or other similar criterion;
8. If the adverse benefit determination is based on a lack of medically necessity, experimental treatment or similar exclusion or limit, then UHC must provide an explanation of the scientific or clinical judgment for the adverse benefit determination as it applies to the claimant's medical circumstances;
9. The name, address, direct telephone number, state license number, medical license number, and the complete name and title of the person making any decisions related to this adverse benefit determination;

10. If this claim is subject to an allowable rate or "Usual, Customary and Reasonable" (UCR) rate adjustment, then UHC must provide the plan documents that permit such an adjustment and the fee schedule used to determine the adjusted amount;
11. A statement of specific legal, medical, or scientific reasons for the adverse benefit determination, if any;
12. If UHC relied upon or referenced a medical policy, UHC must provide complete copies of the studies and/or articles cited in the medical policy and a complete copy of the medical policy;
13. Any additional information that UHC used, cited, referenced, relied upon, or generated in making the adverse benefit determination;
14. Copies of any contracts that UHC has executed with any cost containment or re-pricing companies that effected the medical claim;
15. Complete copy of UHC's Master Contract, Certificate of Coverage, or "Wrap" Plan Document that affects the Shay M Sheppard's plan;
16. Complete copy of the applicable IRS Form 5500 for Shay M Sheppard's plan; and,
17. An explanation as to why UHC does not consider this medical claim to be an Essential Health Benefit.

Refusal to provide all of this information may result in communications being sent directly to Shay M Sheppard's plan.

If UHC denied, delayed, or withheld payment in full based upon an alleged failure of Shay M Sheppard, ARS, or the medical provider to show proof of payment of the deductible, co-pay, coinsurance, or other payment prior to the adjudication of the claim, then ARS requests that UHC provide a copy of the exact language, including page number(s), in the Master Plan Document and Summary Plan Document that states the adjudication of the claim and payment will be denied or delayed for failure to show proof of payment. Additionally, ARS requests that UHC explain the methodologies it used, as well, as copies of the page numbers in the Summary Plan Document and the Master Plan Document to calculate the allowable, the deductible, and the co-pay.

Under the ERISA claims-procedure regulation, 29 CFR § 2560.503-1(f), UHC is required to notify ARS within thirty (30) days of the receipt of this appeal of either: (1) an adverse benefit determination; or (2) an extension for up to fifteen (15) days due to circumstances beyond the plan's control. In the event of an extension, UHC must notify ARS and the member of the circumstances requiring the extension of time and the date by which the plan expects to render a decision. In such an event, pursuant to 29 CFR § 2590.715-2719(b)(2)(ii)(F)(2), ARS demands a written explanation of UHC's delay in processing the claim(s). UHC must provide this explanation within ten (10) days. If UHC contends that the regulations cited in this letter do not apply, then UHC must advise in writing and explain the reasoning to support the contention. In no event should UHC delay the processing of Shay M Sheppard's medical claim.

All information requested in this appeal should be sent to the address listed on the top of the first page. UHC's failure to respond to this request for information in a fair and timely manner, or a failure to allow ARS to present evidence and testimony for consideration as a part of the appeals process, would be a violation of ERISA and the PPACA and would be grounds for seeking remedies under federal and state law.

If there is an anti-assignment clause in the Shay M Sheppard's plan, then UHC is instructed to send any check in Shay M Sheppard's name to 2801 Centerville Road, First Floor, PMB #550, Wilmington, Delaware 19808.

In order to properly communicate and to confirm compliance or noncompliance with these requests, ARS will only respond to written communications. Voice messages or telephone calls may not be returned quickly enough to allow you to comply with federal law.

Best Regards,

Advanced Reimbursement Solutions  
Shay M Sheppard's authorized representative

9  
1  
0  
2  
1  
0  
8  
3  
1  
8  
4  
6  
5