Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Notice of Denial of Medical Coverage

{Replace *Denial of Medical Coverage* with *Denial of Payment*, if applicable}

Date: **Member number:**

Name:

[Insert other identifying information, as necessary (e.g., provider name, enrollee's Medicaid number, service subject to notice, date of service)]

Your request was denied

We've {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} medical services/items listed below requested by you or your doctor [*provider*]:

Why did we deny your request?

We {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} medical services/items listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask {health plan name} to review our decision by asking us for an appeal**.** [Insert Medicaid information explaining whether or not plan level appeal must be exhausted prior to requesting State Fair Hearing. Insert, as applicable: *and/or you can request a State Fair Hearing. You can ask for both types of review at the same time, as long as you meet the deadlines. If you ask us for an appeal first and wait to request a State Fair Hearing, you may miss the deadline for requesting a State Fair Hearing.*]

Plan Appeal: Ask {health plan name} for an appeal within **60 days** [Insert State Medicaid timeframe for internal plan appeals, if different] of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with {health plan name}" for information on how to ask for a plan level appeal.

State Fair Hearing: *Ask for a State Fair Hearing within ( ) days of the date of this notice. You have up to ( ) days if you have a good reason for being late. See section titled "How to ask for a Medicaid State Fair Hearing" of this notice for information about how to ask for a State Fair Hearing.*

How to keep your services while we review your case: *If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed.* ***If you want the service to continue, you must ask for an appeal*** (Insert, if applicable: ***or a State Fair Hearing***) ***within 10 days*** *of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your State Fair Hearing appeal, you may have to pay for these services.*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: {number(s)} to learn how to name your representative. TTY users call {number}. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

Important Information About Your Appeal Rights

There are 2 kinds of appeals with {health plan name}

Standard Appeal – We'll give you a written decision on a standard appeal within **30 days** [Insert timeframe for standard internal plan Medicaid appeals, if different] after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 days**.

{May be deleted if the notice is for a denial of payment: ***Fast Appeal*** *– We'll give you a decision on a fast appeal within* ***72 hours*** *after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.*

We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. *If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 days.*}

How to ask for an appeal with {health plan name}

Step 1: You, your representative, or your doctor [*provider*] must ask us for an appeal [*or State Fair Hearing*]. Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- {May be deleted if the notice is for a denial of payment: *Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).*}
- Any evidence you want us to review, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a fast appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records. [Insert, if applicable: *You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.*]

Step 2: Mail, fax, or deliver your appeal {*or call us*}.
For a Standard Appeal: Mailing Address: {In Person Delivery Address:}
{Phone:} {TTY Users Call:}
Fax:
{Insert, if applicable: *If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.*}

{May be deleted if the notice is for a denial of payment:
For a Fast Appeal: *Phone:* *{TTY Users Call:}*
Fax: }

What happens next?

If you ask for an appeal and we continue to deny your request for {*payment of*} a service, we'll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

[Insert additional State-specific Medicaid rules, as applicable.]

How to ask for a Medicaid State Fair Hearing

*[*Insert only if the enrollee is not required to exhaust the plan level appeal: *You have the right to ask for a State Fair Hearing without asking us (health plan) to review our decision first.]*

Step 1: *You or your representative must ask for a State Fair Hearing (in writing) within ( ) days of the date of this notice. You have up to ( ) days if you have a good reason for your request being late.*

Your {written} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

Step 2: *Send your request to:* Address:
Phone: Fax:

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You'll get a written decision within ( ) days. The written decision will explain if you have additional appeal rights.

[A copy of this notice has been sent to:]

Get help & more information

- {Health Plan Name} Toll Free: TTY users call:
  {Insert plan hours of operation} or {plan website}
- 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
- Medicare Rights Center: 1-888-HMO-9050
- Elder Care Locator: 1-800-677-1116 or www.eldercare.gov to find help in your community.
- [Medicaid/State contact information]
- {State or local aging/disability resources contact information}