Date of Notice
Name of Plan **Telephone/Fax**
Address **Website/Email Address**

This document contains important information that you should retain for your records.
This document serves as notice of an adverse benefit determination. We have declined to provide benefits, in whole or in part, for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal (see the back of this page for information about your appeal rights).

Case Details:

Patient Name:	**ID Number:**
Address: (street, county, state, zip)	
Claim #:	**Date of Service:**
Provider:	

Reason for Denial (in whole or in part):

Amt. Charged	**Allowed Amt.**	**Other Insurance**	**Deductible**	**Co-pay**	**Coinsurance**	**Other Amts. Not Covered**	**Amt. Paid**

YTD Credit toward Deductible:	**YTD Credit toward Out-of-Pocket Maximum:**
Description of service:	**Denial Codes:**

[If denial is not related to a specific claim, only name and ID number need to be included in the box. The reason for the denial would need to be clear in the narrative below.]

Explanation of Basis for Determination:
If the claim is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the definition of a plan or policy term, include that information here.

[Insert language assistance disclosure here, if applicable.
SPANISH (Español): Para obtener asistencia en Español, llame al [insert telephone number].
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa [insert telephone number].
CHINESE ( ): □□□□□□□□□□□□□□□□□□ [insert telephone number]□
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' [insert telephone number]. **]**

Important Information about Your Appeal Rights

What if I need help understanding this denial? Contact us at [insert contact information] if you need assistance understanding this notice or our decision to deny you a service or coverage.

What if I don't agree with this decision? You have a right to appeal any decision not to provide or pay for an item or service (in whole or in part).

How do I file an appeal? [Complete the bottom of this page, make a copy, and send this document to {insert address}.] [or] [insert alternative instructions] See also the "Other resources to help you" section of this form for assistance filing a request for an appeal.

What if my situation is urgent? If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also [insert instructions for filing request for simultaneous external review)].

Who may file an appeal? You or someone you name to act for you (your authorized representative) may file an appeal. [Insert information on how to designate an authorized representative.]

Can I provide additional information about my claim? Yes, you may supply additional information. [Insert any applicable procedures for submission of additional information.]

Can I request copies of information relevant to my claim? Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting us at [insert contact information].

What happens next? If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

Other resources to help you: For questions about your rights, this notice, or for assistance, you can contact: [if coverage is group health plan coverage, insert: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, insert State Department of Insurance contact information]. [Insert, if applicable in your state: Additionally, a consumer assistance program can help you file your appeal. Contact [insert contact information].]

Appeal Filing Form

NAME OF PERSON FILING APPEAL: _____
Circle one: Covered person Patient Authorized Representative
Contact information of person filing appeal (if different from patient)
Address:_____Daytime phone:_____Email:_____

If person filing appeal is other than patient, patient must indicate authorization by signing here:
_____

Are you requesting an urgent appeal? Yes No

Briefly describe why you disagree with this decision (you may attach additional information, such as a physician's letter, bills, medical records, or other documents to support your claim)**:**
_____
_____

Send this form and your denial notice to: [Insert name and contact information]
Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.