

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}

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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)]

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### Your request was {Insert appropriate term: *partially approved, denied*}

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

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### Why did we deny your request?

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

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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 plan level appeal must be exhausted prior to requesting State Fair Hearing or other state external review.]

**Plan Appeal:** Ask {health plan name} for an appeal within **60 days** 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.

**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 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 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 {insert appropriate timeframe for medical service/item or Part B drug: **30 days, 7 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 {medical service/item or Part B drug} you've already received, we'll give you a written decision within **60 days**.

**Fast Appeal** – We'll give you a decision on a fast appeal within {insert appropriate timeframe for medical service/item or Part B or Medicaid drug: **72 hours, 24 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. You cannot request an expedited appeal if you are asking us to pay you back for a {*medical service/item or Part B drug*} you've already received.

**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. Your {*written*} request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- 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 {*medical service/item or Part B drug or Medicaid drug*}. Call your doctor if you need this information.

If you're asking for an appeal and missed the deadline, you may include your reason for being late.



## 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.acl.gov](http://www.eldercare.acl.gov) to find help in your community.
- [Medicaid/State contact information]
- {State or local aging/disability resources contact information}

{May insert instructions for how enrollees can receive this notice in an alternate language or format from the plan.}

**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [www.Medicare.gov/about-us/accessibility-nondiscrimination-notice](http://www.Medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.