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)]

Coverage for your medical services/items was ~~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 Medicare Part B drug or Medicaid drug*} listed below that~~requested by~~ you or your doctor [*provider*] requested:

Why was coverage~~did we deny~~ {Insert appropriate term: denied, partially approved, stopped, reduced, suspended}~~ your request~~?

We {Insert appropriate term: *denied, partially approved, stopped, reduced, suspended*} the {*payment of*} {*medical services/items or Medicare Part B drug 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}:

~~You should s~~Share a copy of this decision with your doctor [*provider*] and discuss next steps. If your doctor [provider] asked for coverage on your behalf, we already sent them a copy of this denial notice~~decision~~.

You have the right to appeal our decision

You have the right to ~~A~~ask {health plan name} to review our decision by asking us for an appeal within **65 calendar days** of the date~~ listed at the top~~ of this notice. If you ask for an appeal after 65 days~~ of the date of this notice~~, you must explain why your appeal is late. See "How to ask for an appeal with {health plan name}" on the next page. [Insert Medicaid information explaining plan level appeal must be exhausted before asking for a State Fair Hearing or other state external review.]

[If you need help getting a Medicaid service, asking for a Medicaid appeal, or would like to request information to support your Medicaid appeal, contact {health plan name} at {Insert toll free and TTY phone numbers} {Insert plan hours of operation}.]

~~**Plan Appeal:** Ask {health plan name} for an appeal within **65 calendar days** of the date listed at the top of this notice. If you ask for an appeal after 65 days of the date of this notice, you must explain why your appeal is late. See "How to ask for an appeal with {health plan name}" on the next page.~~

*[**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. For **~~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 doctor ~~,~~[provider] must agree that you should keep~~continue~~ getting the service. ~~If you lose your appeal, y~~You may have to pay for these services if you lose your appeal.]*

If you want someone else to act for you

You can name a relative, friend, attorney, doctor [provider], 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.~~

Important Information About Your Appeal Rights

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

Standard Appeal

- **Request for Service**: For services you haven't received yet, ~~W~~we'll give you a written decision ~~on a standard appeal~~ within {insert appropriate timeframe for medical service/item or Medicare Part B drug: *30 days, 7 days*} [Insert timeframe for standard internal plan Medicaid appeals, if different] after we get your appeal. [insert for requests for medical service/item: *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.*]

- **Request for Payment**: For appeals related ~~If your appeal is for~~to payment of a {medical service/item or Medicare Part B drug} you already received, we'll give you a written decision within 60 days.

Fast Appeal (only available for service requests)~~—~~

- We'll give you a decision on a fast appeal within 72 hours [Insert timeframe for expedited internal plan Medicaid appeals, if different] after we get your appeal. You can ask for a fast appeal if you or your doctor [provider] believe your health could be seriously harmed by waiting for a standard appeal. ~~up to {insert appropriate timeframe for medical service/item or Part B drug: ***30 days, 7 days***} for a decision.~~ You can't ask for a fast~~n expedited~~ appeal if you're asking us to pay you back for a {*medical service/item or Medicare Part B drug*} you already received.

- We'll automatically give you a fast appeal if a doctor [provider] asks for one for you or ~~if your doctor~~ supports your request. ~~If you ask f~~For a fast appeal without support from a doctor [provider], we'll decide whether~~if~~ your request requires a fast appeal. If we don't

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give you a fast appeal, we'll process a standard appeal.~~give you a decision within {insert appropriate timeframe for medical service/item or Part B drug: *30 days, 7 days}.*~~

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

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

- Your name
- Address
- Plan Member number
- Reasons for appealing
- Whether you want a s~~S~~tandard or f~~F~~ast a~~A~~ppeal (for a f~~F~~ast a~~A~~ppeal, explain why you need one).
- Any evidence you want us to review, like~~such as~~ medical records, doctor supporting statements, ~~s' letters (such as a doctor's supporting statement if you ask for a fast appeal),~~ or other information that explains why you need the {*medical service/item or Medicare 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 can ask for an extension and should include your reason for being late.

~~We recommend k~~Keep~~ing~~ 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, y~~You can also ask for a copy of the guidelines we used to make our decision at no cost to you*.]

Step 2: Submit your appeal by ~~M~~mail, phone, fax, or~~ online~~~~deliver your appeal~~. ~~{*You can also call us or submit your appeal online}*~~

For a Standard Appeal:	Mailing Address:	{Carrier~~In Person~~ Delivery Address:}
	{Phone:}	{TTY Users Call:}
	Fax:	{Online~~Website~~:}

{Insert, if applicable: *If you ask for a standard appeal by phone, we'll send you a letter confirming what you told us.*}

For a Fast Appeal:	Phone:	{TTY Users Call:}
	{Fax:}	{Online~~Website~~:}

What happens next?

If you ask for an appeal and we continue to deny your request for {*payment of*} a {*medical service/item or Medicare Part B drug or Medicaid drug*}, we'll 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

If [health plan name] denies your appeal request, you can ask for a State Fair Hearing. [States may also have additional language regarding other external review processes.]

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

[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}
- **Medicare:** 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 eldercare.acl.gov/Public/Index.aspx ~~eldercare.acl.gov~~ to find help in your community
- [Medicaid/State contact information]
- {State or local aging/disability resources contact information}
- **State Health Insurance Program** ~~**National Technical Assistance Center**~~: call your State Health Insurance Assistance Program for free, personalized health insurance counseling. Visit SHIPhelp.org or call 1-877-839-2675 to get the number for your local SHIP.~~877-839-2675~~

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

Get information in another format

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 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.

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 information collection is 0938-0829. This information collection is for the notice Medicare health plans must provide when a request for either a medical service or payment is denied, in whole or in part. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1852(g)(1)(B) of the Act and the regulatory authority set forth in Subpart M of Part 422 at 42 CFR 422.568, 422.572, 417.600(b), and 417.840. If you have 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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