

Model Notice of Adverse Benefit Determination

OMB Control No.: 1210-0144  
 Expiration Date: 05/31/2025

**Date of Notice**  
**Name of Plan**  
**Address**

**Telephone/Fax**  
**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:**

<b>Patient Name:</b>	<b>ID Number:</b>
<b>Address: (street, county, state, zip)</b>	
<b>Claim #:</b>	<b>Date of Service:</b>
<b>Provider:</b>	

**Reason for Denial (in whole or in part):**

<b>Amt. Charged</b>	<b>Allowed Amt.</b>	<b>Other Insurance</b>	<b>Deductible</b>	<b>Co-pay</b>	<b>Coinsurance</b>	<b>Other Amts. Not Covered</b>	<b>Amt. Paid</b>
<b>YTD Credit toward Deductible:</b>			<b>YTD Credit toward Out-of-Pocket Maximum:</b>				
<b>Description of service:</b>			<b>Denial Codes:</b>				

*[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, kwijjigo holne' [insert telephone number].
- [Pennsylvania Dutch (Deutsch): Fer Hilf griege in Deutsch, ruf [insert telephone number] uff.]
- [Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni [insert telephone number].]
- [Carolinian (Kapasal Falawasch): ngere aukke ghut allillis reel kapasal Falawasch au fafaingi tilifon ye [insert

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telephone number].]

[Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, a'gang [insert telephone number].]

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 **1210-0144 (Expires 05/31/2025)**. This document serves as notice of an adverse benefit determination and informs of the right to appeal. The responses to this information collection are mandatory. The time required to complete this information collection is estimated to average between 30 minutes and 1 hour per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this information collection, please write to: U.S. Department of Labor, Employee Benefits Security Administration, Office of Research and Analysis, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email [ebesa.opr@dol.gov](mailto:ebesa.opr@dol.gov) and reference the OMB Control Number 1210-0144.

## 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].]

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### 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):

\_\_\_\_\_

\_\_\_\_\_

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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.**