

MODEL NOTICE

Date:

Enrollee Name:

Enrollee ID Number:

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**NOTICE OF RIGHT TO AN EXPEDITED GRIEVANCE**

**This notice informs you about your right to file an expedited grievance**

\_\_\_\_\_ You are receiving this notice because we are denying your request for a fast (expedited) decision about your request for a service.

\_\_\_\_\_ You are receiving this notice because we are denying your request for a fast (expedited) appeal for a service.

**Your request has been transferred to our regular processing time frame.**

You can file an expedited grievance whenever we do not provide a fast decision about your initial request for a service, or your request to appeal our denial of a service.

**This notice informs you about your right to file an expedited grievance**

\_\_\_\_\_ You are receiving this notice because we need to take extra days (take an extension) to decide on your request for a service.

\_\_\_\_\_ You are receiving this notice because we need to take extra days (take an extension) to consider your appeal for a service.

**An extension allows us up to 14 additional calendar days to make our decision about your request.**

**What happens during an expedited grievance?**

We must decide within 24 hours if our decision to deny or delay making an expedited decision in your case puts your life or health at risk.

If we determine that we should have expedited your request we will do so immediately and notify you of our decision.

**Please call us at {insert phone number of health plan contact} if you want to file an expedited grievance, or want more information.**

**You can also call 1-800-MEDICARE for more information about the expedited grievance process.**