[*Send this notice in all cases where, after considering both Medicare and Medicaid coverage, an MMP denies, or partially denies, a service, item, Part B drug, or Medicaid drug. If an MMP determines that a service, item, Part B drug, or Medicaid drug is covered, for example, under Medicaid but not under Medicare and thus is provided to the member as requested by the member, do NOT send this notice. Under the terms of the three-way contract, such a situation does not constitute a denial or partial denial.*]

**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 toward the end under “Get help & more information.”You can also see Chapter 9 of the *Member Handbook* for information about how to make an appeal.

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*).]

# Your request was denied

We’ve [*insert appropriate term:* denied, stopped, reduced, suspended] the [*insert if applicable:* payment of] [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug] listed below requested by you or your [*insert as applicable:* doctor *or* provider]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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## Why did we deny your request?

We [*insert appropriate term:* denied, stopped, reduced, suspended] the [*insert if applicable*: payment of] medical services/items listed above because [*Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision*]:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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[*Where the plan has determined that the drug is covered under Medicare Part D, insert the following text:* This request was denied under your Medicare Part B benefit; however, coverage/payment for the requested drug(s) has been approved under Medicare Part D. [*Insert, as applicable, an explanation of the conditions of approval in a readable and understandable format*]. If you think Medicare Part B should cover this drug for you, you may appeal.]

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 a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”).

**Level 1 Appeal with <health plan name>:** Ask <health plan name> for a Level 1 Appeal within **60 calendar 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 a Level 1 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 calendar days** of the date of this noticeor before the service is stopped or reduced, whichever is later. |
| --- |

## 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: <phone number(s)> to learn how to name your representative. TTY users call <TTY 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.

There are 2 kinds of Level 1 appeals with <health plan name>[*Delete this heading if the notice is for a denial of payment, and delete the Fast Appeal section below as well*.]

**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 calendar days**, **7 calendar days**] 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 [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug] you’ve already received, we’ll give you a written decision within **60 calendar days**.

[*May delete if the notice is for a denial of payment*: **Fast (Expedited) Appeal** – We’ll give you a decision on a fast appeal as expeditiously as your condition requires, and always within **72 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 for a decision on a standard appeal.

**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 [*insert appropriate timeframe for medical service/item or Part B drug:* **30 calendar days**, **7 calendar days**].]

# How to ask for a Level 1 Appeal with <health plan name>

**Step 1:** You, your representative, or your provider must ask for an appeal within **60 calendar days** of getting this notice.

Your [*insert if applicable:* written] request must include:

* Your name
* Address
* Member number
* Reasons for appealing
* [*May delete if the notice is for a denial of payment*: 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 [*may delete if the notice is for a denial of payment*: (such as a doctor’s supporting statement if you request a fast appeal)], or other information that explains why you need the [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug]. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

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, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal or call us.

**For a Standard Appeal:** Mailing Address:

[*Insert as applicable:* In Person Delivery Address:]

Phone: TTY Users Call:

Fax:

[*Insert as applicable:* Email Address:]

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

[*May delete if the notice is for a denial of payment:*

**For a Fast Appeal:** Phone: TTY Users Call:

Fax:

[*Insert as applicable:* Email Address:]]

## What happens next?

If you ask for a Level 1 Appeal and we continue to deny your request for [*insert if applicable*: payment of] a service, we’ll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will 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.

If the service was a Medi-Cal service, you can ask for a State Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

# How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree.

Step 1: You or your representative must ask for a State Hearing within 120 days of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the “Form to File a State Hearing” that is included with this notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services

State Hearings Division

P.O. Box 944243, Mail Station 9-17-37

Sacramento, CA 94244-2430

FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

## What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You’ll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision that will explain if you have additional appeal rights.

[*Insert, if applicable:* A copy of this notice has been sent to: [*insert name*].]

# Get help & more information

* Call **<health plan name>** at <phone number>, <plan hours of operation>. TTY users call <phone number>. You can also visit our website at <plan website>.
* Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.
* Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
* Call the **Medicare Rights Center** at 1-888-HMO-9050.
* Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.
* Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.
* You can also see **Chapter 9 of the *Member Handbook*** for information about how to make an appeal.

[*Plan must include all applicable disclaimers as required in the State-specific Marketing Guidance*.]

ATTENTION: If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call [insert Member Services toll-free phone and TTY numbers, and days and hours of operation]. The call is free.[*This disclaimer must be included in all non-English languages that meet the Medicare and/or state thresholds for translation.*]

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Member Services toll-free phone and TTY numbers, days and hours of operation*]. The call is free.