[FIDA-IDD PLAN NAME/LOGO]

**Appeal Level:** **1**

**1 2 3 4**

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**Appeal Decision Notice**

**Name: Date of Notice:**

**Participant Number:**

[*Insert other identifying information, as necessary (e.g., provider name, Participant’s Medicaid number, service subject to notice, date of service)*]

Dear <Participant name>,

<Plan name> reviewed your appeal, received on <date appeal received, orally or in writing> [*for expedited appeals insert:* at <hour received>], about the following action: [*Insert a detailed description of the FIDA-IDD Plan action/IDT decision (e.g. denial, reduction, Life Plan renewal, etc.) being appealed and the benefits involved (provide more detail than the Appeal Acknowledgement letter). Also, include the original rationale for the FIDA-IDD Plan action/IDT decision that is the basis of the Participant’s appeal.*]

**Level 1 Appeal decision**

The appeal was decided in your favor on <date of appeal decision>. That means we [*Insert as applicable:* reversed *or* modified] the previous decision made on <date of plan coverage determination or Life Plan update, as applicable>.

**What this means**

Because our Level 1 Appeal decision is fully in your favor, you are authorized to get the following services as of <date authorized (no later than one business day after the FIDA-IDD Plan appeal decision date)>: [*List the services that were approved, including any applicable information about coverage amount, duration, etc.*]

If you do not get the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

You can also contact the **Independent Consumer Advocacy Network (ICAN)** to help you resolve the issue. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

**Getting your case file**

You can ask to look at the medical records and other documents we reviewed during your appeal. You can also ask for a copy of the guidelines we used to make our decision. You or your representative (if you have one) may ask for these documents, at no cost, by calling <phone number> or by fax to <fax number>.

[*The plan must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:*]

A copy of this notice has been sent to: <name>

<address>

<phone number>

**Get help & more information**

(TTY users call 711, then use the phone numbers below)

| * <Plan name>   Website: <plan website>  Toll Free Phone: <phone number>  TTY users call: <TTY number>  <days and hours of operation>   * Independent Consumer Advocacy Network (ICAN)   Website: [icannys.org](http://icannys.org/)  Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  Toll Free Phone: 1-844-614-8800  8:00am – 8:00pm, Monday – Sunday   * Medicare Rights Center   Toll Free Phone: 1-800-333-4114 | * 1-800-MEDICARE (1-800-633-4227)   TTY users call: 1-877-486-2048  24 hours a day, 7 days a week   * NYS Department of Health   Bureau of Managed Long Term Care  Toll Free Phone: 1-866-712-7197   * NYS Office for People With Developmental Disabilities (OPWDD)   Toll Free Phone: 1-866-946-9733 |
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[*Plan must include all applicable disclaimers as required in the State-specific Marketing Guidance*.]

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