Notice of Receipt of Oral Appeal

<Health plan/PIHP name>

**Important:** We are sending you this notice because you told us that you wanted us to review a decision we made to deny, suspend, or reduce a service to you. Your request is considered an appeal. This notice explains the next steps in the appeal process.

Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under “Get help & more information.”

**Mailing Date:** <Mailing Date> **Member ID:** <Member’s Plan ID Number>

**Name:** <Member’s Name> **Beneficiary ID:** <Member’s Medicaid ID Number>

[*If the plan uses the Beneficiary (Medicaid) ID Number as its Plan ID Number, replace the two fields above with one field formatted as follows:* Member/Beneficiary ID: <Member’s Medicaid ID Number>.]

**This notice is in response to a request that we received on <date received>.**

**Type of Service Subject to Notice:**  **Medicare**  **Medicaid**  **Medicare/Medicaid Overlap Service**

**We got your appeal**

We understand that you want us to review our decision: <decision being appealed> \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You want us to review our decision because: <member’s reason for appeal>

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**If any of this is not correct or if you do not want us to review our decision for any reason, you must let us know as soon as possible. You can call your Care Coordinator or Member Services at: <toll-free phone number> (TTY: <toll-free TTY number>), <days and hours of operation>.**

If we have correctly described your appeal, we will begin processing it immediately. For our records, please sign the attached Acknowledgment form and send it back to us in the enclosed stamped, self-addressed envelope.

We received your appeal on <date received>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

**What this means**

We will make a decision by **<date received plus thirty (30) days for non-Medicare Part B prescription drug cases or date received plus seven (7) days for a Medicare Part B prescription drug case>**. We will mail you a letter telling you what our decision is and why we made that decision. If your appeal is for payment of a [*insert as applicable:* medical service/item *or* Part B drug *or* Medicaid drug] you’ve already received, we’ll give you a written decision within **60 calendar days**. 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.

[*Insert, if applicable*: Your appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving will continue while we review your appeal.]

We may contact you for more information or if we have questions. If you have any questions or more information to provide, please call <appeals-specific phone number/fax number>.

**If you want someone to represent you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative at any time. 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.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

**Get help & more information**

* **<Health plan name>**: If you need help or additional information about our decision and the appeal process, call Member Services at: <toll-free phone number> (TTY: <toll-free TTY number>), <days and hours of operation>. You can also visit our website at <MMP web address>.
* **MI Health Link Ombudsman**: You can also contact the MI Health Link Ombudsman for help or more information. The staff can talk with you about how to make an appeal and what to expect during the appeal process. The MI Health Link Ombudsman is an independent program, and the services are free. Call 1-888-746-6456 (TTY: 711). The MI Health Link Ombudsman is available Monday through Friday, 8 am to 5 pm.
* **Medicare**: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week
* **Medicare Rights Center**: 1-800-333-4114, Monday through Friday
* **Elder Care Locator**: 1-800-677-1116 (Monday through Friday, 9 am to 8 pm) or [www.eldercare.acl.gov](http://www.eldercare.acl.gov) to find help in your community
* **Michigan Medicare/Medicaid Assistance Program (MMAP)**: 1-800-803-7174
* **Michigan Department of Health and Human Services (MDHHS) Beneficiary Help Line**: 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet- based phone service).
* [*If applicable, insert other state or local aging/disability resources contact information.*]

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

[*PIHPs in Region 1 insert:* NorthCare Network is a behavioral health plan that subcontracts with the Upper Peninsula Health Plan, which is a health plan that contracts with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.]

[*PIHPs in Region 4 insert:* Southwest Michigan Behavioral Health is a behavioral health plan that subcontracts with Aetna Better Health of Michigan and Meridian Health Plan of Michigan, which are health plans that contract with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.]

[*PIHPs in Region 7 and 9 insert:* <PIHP’s legal or marketing name> is a behavioral health plan that subcontracts with Aetna Better Health of Michigan, AmeriHealth Michigan, Michigan Complete Health, HAP Midwest Health Plan, and Molina Healthcare of Michigan, which are health plans that contract with both Medicare and Michigan Medicaid to provide benefits of both programs to enrollees.]

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 may increase the font size and/or use bold font to emphasize the following information.*] You can also 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, and days and hours of operation*]. The call is free.

**ACKNOWLEDGMENT**

I have read the notice regarding my appeal and agree that it correctly says what I want to appeal and my reasons for asking for the appeal. I want a final decision on this appeal.

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<Member’s Name>