<Plan logo> <Healthy Connections Prime logo>

[*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 on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

[*Replace* Denial of Medical Coverage *with* Denial of Payment, *if applicable*]

**Date: Member Number:**

**Name:**

**Service Subject to Notice: Type of Service:** [*insert as applicable:* Medicare-only, Healthy Connections Medicaid-only, both Medicare and Healthy Connections Medicaid]

**Date of Service: Provider Name:**

**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* Healthy Connections Medicaid drug] listed below requested by you or your [*insert as applicable:* doctor *or* provider]:

[*Insert if this is a post-service case for which there is no member liability:* **Please note, you will not be billed or owe any money for this** [*insert as applicable*: **medical service/item** *or* **Part B drug** *or* **Medicaid drug**].]

**Why did we deny your request?**

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

[*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 provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

**You have the right to appeal** **our decision**

You have the right to ask <plan name> to review our decision by asking us for a Level 1 Appeal.

Ask <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. Refer to the section titled “How to ask for a Level 1 Appeal with <plan name>” for information on how to ask for a plan level appeal.

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| **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 days** of the date of this noticeor before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service.[*Plans must insert this sentence if they pursue cost recovery*:If you lose your appeal, you may have to pay for these services*.*] |

**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.

**Important Information About Your Appeal Rights**

**There are 2 kinds of appeals with <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 service/item *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 Appeal** – We’ll give you a decision on a fast appeal 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 up to [*insert appropriate timeframe for medical service/item or Part B drug:* **30 calendar days**, **7 calendar days**] for a decision.

**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 <plan name>**

**Step 1:** You, your representative, or your provider must ask us for an appeal. Your 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 item or service. 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 look at 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 send you a letter confirming what you told us.

[*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?**

**Medicare-only service**

If you ask for an appeal for a Medicare-only service and we say *No* at Level 1, we’ll send you a written decision and automatically send your case for a Level 2 Appeal with an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

**Healthy Connections Medicaid-only service**

If you are appealing a Healthy Connections Medicaid-only service and we say *No* at Level 1, you can file a Level 2 Appeal. A Level 2 Appeal for Healthy Connections Medicaid is called a “State Fair Hearing.” We do not automatically file a State Fair Hearing request for you. [*Plans may insert the following if applicable:* We will, however, forward your case to the Healthy Connections Prime Advocate, who will check with you to find out if you want to request a State Fair Hearing. You do not have to wait for the Healthy Connections Prime Advocate to contact you before filing your request.] You must make your request in writing to the Division of Appeals and Hearings. More information is below.

**Both Medicare and Healthy Connections Medicaid service**

If you are appealing a service covered by both Medicare and Healthy Connections Medicaid and we say *No* at Level 1, you will automatically get a Level 2 Appeal with the independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights. At the same time, you can also ask for a Level 2 State Fair Hearing in writing with the Division of Appeals and Hearings. [*Plans may insert the following if applicable:* We will forward your case to the Healthy Connections Prime Advocate, who will check with you to find out if you want to request a State Fair Hearing. You do not have to wait for the Healthy Connections Prime Advocate to contact you before filing your request.] More information is below.

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| How to ask for a Healthy Connections Medicaid State Fair Hearing  You can only ask for a State Fair 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 Fair Hearing in writing within 120 calendar days of the date of the plan’s Level 1 Appeal decision. The State can extend this deadline if you have a good reason for your request being late. If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed if you ask for a State Fair Hearing on or before 10 days from the date of the plan’s Level 1 Appeal decision or the intended effective date of the action, whichever is later.  Your written request must include:   * Your name * Address * Member number * Reasons for appealing * A copy of the appeals decision notice * Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.   Step 2: Send your request to: Online: [msp.scdhhs.gov/appeals](https://msp.scdhhs.gov/appeals)  Phone: Toll Free: 1-800-763-9087 or Local: 1-803-898-2600  Fax: 803-255-8206  Address: Division of Appeals and Hearings  South Carolina Department of Health and Human Services  P.O. Box 8206  Columbia, SC 29202-8206  What happens next?  The State will hold a hearing. You may attend the hearing in person. 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 within 90 calendar days from the date you filed an appeal with the plan. If you or your authorized representative asks for a fast decision, and the State agrees that expedited resolution is required, the decision will be issued within three business days from the date of the hearing request. The written decision will explain if you have additional appeal rights.  [Insert if applicable: A copy of this notice has been sent to:] |

**Get help & more information**

<Plan name>’s Member Services can provide more information and help. Call us at <toll-free phone number>, <days and hours of operation>. TTY users call <toll-free phone number>. You can also visit our website at <web address>.

You can also call the Healthy Connections Prime Advocate. The advocate is not part of Healthy Connections Medicaid or <plan name>. They can explain the appeals process to you, and they will act in your best interest during the process. They can also help you find other resources for assistance. You can reach the Healthy Connections Prime Advocate at 1-844-477-4632. TTY users call 711.

You can also call Medicare directly for help. Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY: 1-877-486-2048. The call is free.

[*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 Member Services toll-free phone and TTY numbers, days and hours of operation*]. The call is free.