**Notice of Our Failure to Make a Coverage Decision**

<Health plan/PIHP name>

**Important:** We did not respond to your request for coverage within the required time period. This notice explains your right to appeal our failure to respond. 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.”

**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>.]

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

**We did not make a decision on your request**

<Health plan/PIHP name> received your request for coverage on <enter date received>. As of the date of this notice, we have not made a decision on the services/items listed below requested by you or your [*insert as applicable:* doctor *or* provider]:

You should share a copy of this notice 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 notice to your doctor.

**You have the right to appeal our failure to decide**

According to federal regulations, we must make a coverage decision within 14 calendar days for standard requests and 72 hours for expedited requests (with a possible 14 calendar day extension). Our failure to make a timely decision is considered a denial of coverage. You have the right to appeal this denial by asking us for an internal appeal.

**Internal Appeal:** Ask <health plan/PIHP name> for an internal 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 an internal appeal with <health plan/PIHP name>” for information on how to ask for a plan level appeal.

**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 <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 internal appeals with <health plan/PIHP 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 **30 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 service 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 30 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 30 calendar days.]

**How to ask for an internal appeal with <health plan/PIHP name>**

**Step 1:** You, your representative, or your [*insert as applicable:* doctor *or* provider] must ask us for an internal 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.

[*Insert, if applicable:* 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:]

[*Insert, if applicable:* 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?**

If you ask for an internal appeal and we deny your request for coverage or payment of a service, we will send you a written decision. The letter will tell you if the service or item is usually covered by Medicare and/or Michigan Medicaid.

* If the service is covered by Medicare, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, you will receive a written decision that will explain if you have additional appeal rights.
* If the service is covered by Michigan Medicaid, you can ask for a Fair Hearing. [*ICOs must insert*: You can also ask for an External Review under the Patient Right to Independent Review Act (PRIRA).] Your written decision will give you instructions on how to request a Fair Hearing [*ICOs must insert:* and External Review]. Information about the Fair Hearing process is also below.
* If the service could be covered by both Medicare and Michigan Medicaid, we will automatically send your case to an independent reviewer. You can also ask for a Fair Hearing [*ICOs must insert:* or an External Review].

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| How to ask for a Michigan Medicaid Fair Hearing  You must file an internal appeal with the plan before asking for a Fair Hearing.  You have 120 calendar days from date of our written decision, called the Notice of Appeal Decision, to ask for the Fair Hearing. A Request for Hearing form will be included with the Notice of Appeal Decision. It also has instructions that you should review.  Step 1: You, your representative, or your [insert as applicable: doctor or provider] must ask for a Fair Hearing. Your written request must include:   * Your name * Address * Member number * Reasons for requesting a Fair Hearing * Any evidence you want the Administrative Law Judge 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: Address: Michigan Office of Administrative Hearings and Rules (MOAHR)  PO Box 30763  Lansing, MI 48909  Phone: 1-800-648-3397 Fax: 517-763-0155  **What happens next?**  The Michigan Office of Administrative Hearings and Rules (MOAHR) will schedule a hearing. You will get a written “Notice of Hearing” telling you the date and time. Most hearings are held by telephone, but you can ask to have a hearing in person. During the hearing, you’ll be asked to tell an Administrative Law Judge why you need the requested service/item. 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 your Request for Hearing was received by MOAHR. The written decision will explain if you have additional appeal rights.  If the standard timeframe for review would put your life or health at risk, you may be able to qualify for an expedited (fast) Fair Hearing. Your request must be in writing and clearly state that you are asking for a fast Fair Hearing. Your request can be mailed or faxed to MOAHR (see address and fax number for MOAHR above). If you qualify for a fast Fair Hearing, MOAHR must give you an answer within 72 hours. However, if MOAHR needs to gather more information that may help you, it can take up to 14 more calendar days.  If you have any questions about the Fair Hearings process, including the expedited (fast) Fair Hearing, you can call MOAHR at 1-800-648-3397.  [Insert as applicable: A copy of this notice has been sent to:] |

**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 <plan website>.
* **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: 1-877-486-2048), 24 hours a day, 7 days a week
* **Medicare Rights Center**: 1-888-HMO-9050, Monday through Friday
* **Eldercare 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). You can also email [beneficiarysupport@michigan.gov](mailto:beneficiarysupport@michigan.gov).
* [*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.*]

[*As applicable, PIHPs may use one IDN model for all MMPs they subcontract with. PIHPs may include one Material ID at the bottom of the first page of the IDN that contains all applicable MMP contract numbers (e.g.,* H8026\_H0192\_H9712\_H9487\_H7844\_PIHP IDN Region 7*)*.]

[*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.

[*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)*.*]