Notice of Receipt of Appeal/Grievance

<Health plan/PIHP name>

**Important:** 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**

**You Filed A Grievance**

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

**WHAT THIS MEANS**

We will review your grievance by <date received plus 30 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

**You Filed An Appeal**

We received your appeal on <date received>. You are appealing our decision to <description of subject of appeal>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

**WHAT THIS MEANS**

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

[*Insert, if applicable*: <The 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 the appeal is being reviewed.>]

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

**FOR BOTH GRIEVANCES AND APPEALS**

**If you want someone to represent you**

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

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 <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)*.*]