**APPEAL DECISION NOTICE (Medicaid Only [Non-Waiver] Services)**

If you speak Spanish, language assistance services, free of charge, are available to you. Call [i*nsert Member Services toll-free phone and TTY numbers, and days and hours of operation*]. The call is free. [*This disclaimer must be included in Spanish.*]

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

**<<today\_date\_mmmm\_ddyyyy>>**

**<<r\_full\_name>>**

**<<r\_full\_address>>**

Re: Member Name **<<m\_full\_name>>**

Member ID No. **<<m\_external\_id>>**

Tracking Number **<<Event or Referral number under which denial was issued>>**

Dear **<<Name>>**:

We have reviewed the appeal received on **<<date>>** for the **<<denial, reduction, suspension, or termination>>** of **<<medical service/treatment>>**. **<<Clearly document the reason for the appeal>>**.

A <Plan Name> **<Medical Director or External Physician Consultant or Registered Nurse>** reviewed your appeal. **[If medical necessity denial, include the following:** The reviewer, **<reviewer name and title>**, is board certified in **<Specialty>**.**]**

After review of the information, we have decided to **<<deny, suspend, reduce, or terminate>>** the service for **<<or payment of>> <<medical service/treatment>>**.

The reason for the decision is **<<explanation for the determination including the actual benefit, provision, guideline, protocol, or other criterion on which the appeal decision was based and any alternative treatment>>**.

You can get a free copy of any document, record, clinical criteria or other information relevant to your case by submitting a request to **<Member Services>** at **<address and/or phone>** (TTY: **<xxx>**) **<days/hours of operation>**. The call is free.

This decision is not intended to limit your care. Your treatment choices are between you and your provider.

If you do not agree with this decision, you can ask for a Medicaid External Independent Review (EIR), a State Fair Hearing, or both. You will not have to pay any costs, including filing fees. Additional information is below.

**How to ask for a Medicaid External Independent Review (EIR)**

A request for an EIR must be submitted in writing to the address below. You must submit your request within **30 days** of the date of this letter. If you want your services to remain in place during the EIR process, you must request an EIR within **ten (10) calendar days** of the date of this letter. You should include your name, address, phone number, tracking number, and reasons for the request. The tracking number can be found at the top of this letter. If you want someone to act on your behalf, such as an attorney, relative, or friend, you must request this in writing.

To request an EIR or if you have questions, you can contact <Plan Name> at:

<Plan Name>

<Grievance and Appeals Coordinator>

<street address>

<toll-free number>

<fax number>

Within five (5) business days after we receive your request, we will review all information. We will then notify you if your request is eligible for an EIR. If your request is eligible, we will notify you of the external review organization chosen to review your information. Within five (5) days of receiving all needed information, the EIR organization will review the information. The organization will decide whether the services are medically appropriate. If the services are ruled medically appropriate, <Plan Name> will approve the service(s). We will notify you orally and in writing of the results of the EIR.

An expedited EIR may be requested if you feel the timeframe for completing a standard EIR could seriously risk your life or health. This includes your being able to reach, keep, or get back to your maximum function. A request for an expedited EIR may be made orally or in writing. If we agree that your request can be expedited, we will send it to the EIR organization within 24 hours of receiving all needed information. The EIR organization will make a decision within one (1) business day. We will notify you orally of the results of the expedited EIR.

**How to ask for a State Fair Hearing**

A State Fair Hearing request must be submitted within **120 calendar days** of the date of this letter. If you want your services to remain in place during the State Fair Hearing process, you must say so when you appeal, and you must ask for a State Fair Hearing within **ten (10) calendar days** of the date of this letter. If you do not win this appeal, you may be responsible for paying for the services provided to you during the appeal. If you want someone to act on your behalf, such as an attorney, relative, or friend, you must request this in writing.

You can ask for a State Fair Hearing in one of the following ways:

Mail: Illinois Department of Healthcare and Family Services

Bureau of Administrative Hearings

69 West Washington Street, 4th Floor

Chicago, IL 60602

Fax: 312-793-2005

Email: [HFS.FairHearings@Illinois.gov](mailto:HFS.FairHearings@Illinois.gov)

Call: 855-418-4421 (TTY users call 800-526-5812)

**[Insert when online submission becomes available***:*

Online: Visit [abe.illinois.gov/abe/access/appeals](https://abe.illinois.gov/abe/access/appeals) to set up an ABE Appeals Account and submit a State Fair Hearing request online. This will allow you to track and manage your appeal online, view important dates and notices, and submit documentation.**]**

Filing a request for a State Fair Hearing or an External Independent Review will not result in discrimination against you.

You can also contact the Illinois Home Care Ombudsman (HCO) Program for help or more information. HCO is an advocate that can talk with you about the State Fair Hearing and what to expect during the hearing process. The HCO program is independent, and the services are free. Here are ways that you can get help from HCO:

* Call 1-800-252-8966 (TTY: 1-888-206-1327). Hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.
* Email [**Aging.HCOProgram@illinois.gov**](mailto:Aging.HCOProgram@illinois.gov)

Sincerely,

<Medical Director>

<Plan Name>

Cc: **<<facility\_name>>**

**<<pcp\_full\_name>>**

**<<treating provider name>>**

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