[*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 at the end under “Get help & more information.”

ATTENTION: If you speak Spanish, 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 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.

Notice of Denial of Medical Coverage

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

**Date: Member number:**

**Name:**

[*Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service)*]

**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* 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* Medicaid drug] listed above because [*provide specific rationale for decision, and include State or Federal law and/or Evidence of Coverage 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 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 decision to your doctor to inform him/her of this decision. Your doctor can call <health plan name> about this decision.

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

You have the right to ask <health plan name> to review our decision by asking us for an appeal. Ask <health plan name> for an 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 section titled “How to ask for an appeal with <health plan name>” for information on how to ask for a plan level appeal.

|  |
| --- |
| **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 the service is a Medicare service, your benefits for that service will continue during the appeal process with <health plan name>. **If the service is a Medicaid service and you want to continue your benefits, you must ask for an appeal within 10 calendar days** of the date of this noticeor before the service is stopped or reduced, whichever is later. 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 <health 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*: **15 business 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 **24 hours** after we get all the necessary information for 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*: **15 business 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*: **15 business days, 7 calendar days**]*.*]

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

**Step 1:** You, your representative, or your [*insert as applicable:* doctor *or* 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.

[*Insert, if applicable*: At no cost to you, you can ask to look at the medical records and other documents we used to make our decision before or during the appeal. 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 appeal and we continue to deny your request for or payment of a service, we’ll send you a written decision. The letter will tell you if the service or item is usually covered by Medicare and/or Medicaid.

If the service was originally a Medicare service or a Medicare-Medicaid overlap service (i.e., services that both programs may cover), 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. For Medicare-Medicaid overlap services, we will send you a separate notice explaining your rights.

If the service was a Medicaid-only service, you can ask for a State Fair Hearing. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

|  |
| --- |
| How to ask for a 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 within 120 calendar days of the date of the health plan’s written decision.  Your request must include:   * Your name * Address * Member number * A copy of the health plan appeal decision * Reasons for appealing * 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: You can ask for a State Fair Hearing in one of the following ways:  [*Insert the following contact information if the denial was for medical services or items, Elderly Waiver (Community Care Program [CCP]) services, or Supportive Living Facilities Waiver services:*  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) 877-734-7429]  [*Insert the following contact information if the denial was for mental health services or items, substance abuse services, Persons with Disabilities Waiver services, Traumatic Brain Injury Waiver services, HIV/AIDS Waiver services, or any Home Services Program (HSP) service:*  Mail: Illinois Department of Human Services  Bureau of Hearings  69 West Washington Street, 4th Floor  Chicago, IL 60602  Fax: 312-793-3387  Email: [DHS.HSPAppeals@Illinois.gov](mailto:DHS.HSPAppeals@Illinois.gov)  Call: 800-435-0774 (TTY users call 877-734-7429)]  [*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.]  What happens next?  The State will hold a hearing. You will receive a letter with information about the hearing. It is important that you read this letter carefully. [Insert when online submission becomes available: If you set up an ABE Appeals Account at [abe.illinois.gov/abe/access/appeals](https://abe.illinois.gov/abe/access/appeals), you can access all letters related to your State Fair Hearing process through your account. You can also upload documents and view appointments.]  You or your authorized representative must attend the hearing in person or by phone. 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. Your appeal will be dismissed if you, or your authorized representative, do not appear at the hearing at the time, date, and place on the notice and you have not requested a postponement in writing.  You’ll get a written decision within 90 calendar days. The written decision will explain if you have additional appeal rights. [Insert when online submission becomes available: If you set up an ABE Appeals Account at [abe.illinois.gov/abe/access/appeals](https://abe.illinois.gov/abe/access/appeals), the decision letter will also be available online through your account.]  [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: <TTY number>), <days and hours of operation>. You can also visit our website at <plan website>.
* **Senior HelpLine**: You can also contact the Senior HelpLine for help or more information. The Senior HelpLine staff can talk with you about how to make an appeal and what to expect during the appeal process. The Senior HelpLine is an independent program, and the services are free. 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.
* 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).
* **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**: 1-800-333-4114
* **Eldercare Locator**: 1-800-677-1116 or [www.eldercare.acl.gov](http://www.eldercare.acl.gov/) to find help in your community.
* **Illinois Department of Healthcare and Family Services** Health Benefits Hotline: 1-800-226-0768 (TTY 1-877-204-1012), Monday through Friday from 8:00 a.m. to 4:45 p.m.

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