[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.]

[Upon request of the Enrollee, their representative, or My Ombudsman MMPs must send a list of coverage documents that it reviewed against for coverage in making its decision on the Enrollee’s request, including but not limited to the Annual Plan Benefit Package for the current Year, Medicare coverage criteria, MassHealth Provider Regulations, MassHealth Bulletins, Enrollee’s Assessment and Care Plan, case notes, and Member Handbook.]

[By sending this notice, MMPs are certifying that all relevant coverage information has been reviewed in making the decision, including relevant Medicare and Medicaid coverage criteria, OneCare three-way contract requirements, member’s Care Plan and other care coordination information, and any other relevant sources of coverage information.]

<Plan Name> Notice of Denial or Change

Denial or Modification of a Requested Service

[Replace Denial or Modification of a Requested Service with Denial of Payment, if applicable]

**IMPORTANT:** For help with this notice, contact:

**<Plan Name>** at <Plan customer service phone/relay numbers>, **OR**

**My Ombudsman at (phone)** [855-781-9898](tel:+18557819898), **(video phone)** [339-224-6831](tel:3392246831), **or (email)** [info@myombudsman.org](mailto:info@myombudsman.org)

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**Date of Notice: Date of Decision:**

**Enrollee Name: Member Number:**

**Service:**

On [*insert date of request*][*insert as appropriate:* you *or* your healthcare provider *or* your care coordinator] asked us to [*Insert as applicable*: **authorize,** *or* **pay for you to get** *or* **pay for the following:**]

* **Description of request:** [*describe the services/items, Part B drug, Medicaid drug and amount, duration, and scope, of what the member requested, e.g. Physical therapy visits 2 times per week for 1 year.*]

**The request for us to** [*insert as applicable*: **authorize** *or* **pay for**] **the** [*insert as applicable*: **service(s)** *or* **items** *or* **Part Bdrug** *or* **Medicaid drug**] **listed above was:**

[*Check and include 1 or more boxes as appropriate and add plain language description for each as appropriate. If a portion of the request is approved, “Approved” and “Denied” should both be checked (and Approval Notice should also be sent).*]

**[ ] Approved:** [*include specifically what the plan is approving, e.g.: N/A, Acupuncture 2 times per week, Wheelchair, Moving a sink to a more accessible location, etc.*]

**[ ] Changed: We are giving you something different from what you asked for:** [*include specifically what was requested and what is approved, e.g.: We are approving Acupuncture services for 3 months instead of a full year, or We are approving moving a toilet to the south wall instead of the east wall of bathroom, or We previously approved 18 Acupuncture visits per year but are now reducing the visits to only allow 10.*]

**[ ] Denied:** [*include specifically what is being denied e.g.: N/A, We are not approving you to receive Acupuncture, we are not approving a grab bar.*]

[*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 or change your request?

We [*Insert appropriate term:* denied *or* changed] therequest for the [*insert as applicable:* medical service(s) *or* items *or* Part B drug *or* Medicaid drug] listed above because: [*Plain language explanation of the decision here should include:* *(1) relevant context for the decision (e.g. if this was something that was approved for the member in the past the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now, such that it is no longer being approved); (2) coverage information considered including but not limited to Medicare and Medicaid coverage benefits, OneCare three-way contract requirements, and the amount allowable under the plan’s benefit package; and, (3) if applicable, information on how or why the requested service or item is not supported by the member’s needs (e.g. your medical records do not show that past Acupuncture visits have helped you improve in the past). Plans must also provide citation of State or Federal regulation or law and, for services with broader OneCare three-way contract coverage, cite Contract requirement. Plans may also include 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.]

# Next Steps

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 (sometimes called an “internal appeal” or “plan appeal”).

You must ask for a Level 1 Appeal within **60 calendar days** of the date of this notice. We may 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 Level 1 Appeal.

If you are appealing becausewe told you that a service you currently get will be changed or stopped, you have a right to keep getting that service while your appeal is processing. If you want the service to continue, you must ask for an appeal **within 10 days of the date of this notice or before the service is changed or stopped**, whichever is later.

# If you want someone else to request an appeal for you

Your provider can request the appeal on your behalf. If you want a relative, friend, attorney, or someone besides your provider to make the appeal for you, you must first complete an Appointment of Representative form. The form gives the other person permission to act for you.

To get an Appointment of Representative form, call Member Services at <phone number> and ask for one, or visit [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207) [*plans may also insert:* or our website at <web address *or* link to form>]. We must get the completed Appointment of Representative form before we can review your request if the appeal comes from someone besides you or your provider.

# Important Information About Your Appeal Rights

**There are two kinds of Level 1 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 must 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. [*For an appeal concerning a payment problem, the plan may substitute the following sentence*: If your appeal is for payment of a [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug] you already got, we must give you our answer within 60 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.

[*May delete if the notice is for a denial of payment:* **Fast (Expedited) Appeal** – We must give you a decision on a fast (expedited) appeal within **72 hours** after we get your appeal request. You can ask for a fast appeal if you or your health care provider believe your health, life, or ability to regain maximum function may be put at risk by waiting up to 30 calendar days for a decision.

**We’ll automatically give you a fast appeal if your health care provider asks for one for you or if your provider supports your request.** If you ask for a fast appeal without support from your health care provider, we’ll decide if your health 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>

You or your authorized representative must ask for a Level 1 Appeal within **60 calendar days** of the date on this notice.

To ask for a standard Level 1 Appeal, you can call, send a letter, <email>,or fax us or ask your provider or representative to ask us for a decision. If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter to confirm the facts of your appeal. The letter will tell you how to make any corrections.

**For a Standard Appeal:** Mailing Address:

[*Insert as applicable:* In Person Delivery Address:]

Phone: TTY Users Call:

Fax:

[*Insert as applicable:* Email Address:]

[*May delete if the notice is for a denial of payment:*

To ask for a fast Level 1 Appeal,you or your provider or representative can call, <email>, or fax your request to us.

**For a Fast Appeal:** Phone: TTY Users Call:

Fax:

[*Insert as applicable:* Email Address:]]

When you make your appeal, you should give us the following information:

* Your name
* Address
* Member number
* Primary language (let us know if you need an interpreter, including American Sign Language or other languages such as Spanish)
* Reason 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, health care providers’ 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 [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug]. Call your health care provider 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.

# What happens next?

If you asked for a Level 1 Appeal, you will get a written notice from us that tells you our decision about your appeal. If we continue to deny your request for[*insert, if applicable:* payment of] a [*insert as applicable:* medical service/item *or* Part B drug *or* Medicaid drug], you have other options:

* If the service is covered by Medicare, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.
* If the service is covered by MassHealth, you will have the right to ask for a Level 2 Appeal from the MassHealth Board of Hearings. If the Board of Hearings denies your request, the written decision will explain your additional appeal rights.
* If the service could be covered by both Medicare and MassHealth, we will automatically send your case to the independent reviewer. You can also ask for a Level 2 Appeal from the MassHealth Board of Hearings.

Please refer to Chapter 9 of your *<*plan name*>* Member Handbook for more information about the Level 2 Appeals process.

# Get help & more information

* **<Plan name>**:If you need any help or additional information about our decision and the appeal process, call <Member Services> at: <phone number> (TTY: <TTY number>), <hours of operation>. You can also visit our website at <plan website>.
* **My Ombudsman**: If you need more help or information, you can also contact My Ombudsman. My Ombudsman is an independent program. My Ombudsman staff can talk with you about how to make an appeal and what to expect during the appeal process. My Ombudsman services are free. Here are the ways to get help from My Ombudsman:
  + Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898.
  + Email [info@myombudsman.org](mailto:info@myombudsman.org).
  + Write to or visit the My Ombudsman office at 25 Kingston Street, 4th floor, Boston, MA 02111.
* Please refer to the My Ombudsman website or contact them directly for updated information about location, appointments, and walk-in hours.
  + Visit My Ombudsman online at [www.myombudsman.org](http://www.myombudsman.org).
* **Medicare**:1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048)
* **Medicare Rights Center**: 1-800-333-4114
* **MassHealth Customer Service**: 1-800-841-2900 (TTY: 1-800-497-4648)
* [*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.*]

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, and days and hours of operation*]. The call is free.