[*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.*]

Notice of Denial of Medical Coverage

[*Replace* Denial of MedicalCoverage *with* Denial of Payment, *if applicable*]

**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 on the last page under “Get help & more information.”

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**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**

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Your request was denied

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* Michigan Medicaid drug] listed below requested by you or your [*insert as applicable:* doctor *or* provider]:

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[*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: [*Include citations with descriptions that are understandable to the member, of applicable State and Federal rule, law, and regulation that support the action. Plans may also include Evidence of Coverage/Member Handbook provisions as well as plan policies/procedures or assessment tools used to support the decision.*]

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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[*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.

### You have the right to appeal our decision

You have the right to ask <health plan/PIHP name> to review our decision 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. Refer to the 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.

|  |
| --- |
| **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 you want the service to continue while your case is under review, 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 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 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 [*insert appropriate timeframe for medical service/item or Part B drug:* **30 calendar 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 **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 [*insert appropriate timeframe for medical service/item or Part B drug:* **30 calendar 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:* **30 calendar days**, **7 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 [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug]. 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 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.]

**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 continue to deny your request for coverage or payment of a [*insert as applicable:* medical service/item *or* Part B drug *or* Medicaid drug], we’ll 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].
* 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].
* If you do not receive a notice or decision about your appeal from the plan within the timeframes listed above, you may seek a Fair Hearing. For more information or to ask for a Fair Hearing, contact the Michigan Office of Administrative Hearings and Rules (MOAHR) at <phone number>.

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 <MMP web address>.
* **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**: 1-800-333-4114, 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.