[*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 or Other Action**

<plan name> Is Proposing to Take

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

**Mailing Date: Medicaid ID Number:**

**Name: Member Number:**

# Action we are proposing to take:

[*Only display the action(s) the plan selects from below.*]

[*Insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug]

**(Service):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

[*Insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug] **Suspended, Reduced, or Terminated**

**(Service):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Denial, in whole or part, of payment for a non-covered** [*insert as applicable:* medical service/item *or* Part B drug *or* Medicaid drug]

**(Service):**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Failure of Plan to Respond to a Request for Prior Authorization (PA) or Resolve an Appeal or Grievance within required timeframe**

[*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 are we taking this action?

We are taking an action regarding the [*insert as applicable:* medical services/items *or* Part B drug *or* Medicaid drug listed above *or* we failed to take an action within the appropriate required timeframe] because [*include citations with descriptions that are understandable to the member, of applicable State or Federal rule, law, and regulation that support the action. 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.]

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. If your doctor would like to discuss this decision with the <plan name> reviewer, he or she can contact us at [*insert* *plan contact information*].

# You have the right to appeal our action

If you don’t agree with this action you, your authorized representative, or the doctor or other provider that requested this service can ask that we change our action. This request is called a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”).

You must ask for an appeal within **60 calendar days** after the mailing date on this notice. We will give you an answer within [*insert appropriate timeframe for medical service/item or Part B drug:* **15 calendar days**, **7 calendar days**] from the date we receive your appeal request.

[*May delete if the notice is for a denial of payment:* If your doctor or other provider believes that the standard timeframe to decide your appeal could seriously risk your life or health, you or the requester should ask for a “fast appeal.” Serious risk to your life or health includes risk to you being able to reach, keep, or get back to your maximum function. If you qualify for a fast appeal, we will give you an answer within 72 hours. If we do not agree with your request for a fast appeal, you may file a complaint with us.]

## How to ask for an appeal with <plan name>

Please call us at <plan phone number> (TTY: <plan TTY number>). An appeal can also be [*plans that accept appeals via fax include:* faxed to <fax number>], sent in writing to <plan address> or submitted via the internet at [*internet address and any specific link directions needed*]. When requesting your appeal, make sure to include:

* Your name
* Address
* Telephone number
* Member number
* Service or action you are appealing
* 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, provider letters [*may delete if the notice is for a denial of payment:* (such as a provider’s supporting statement if you request a fast appeal)], other information that explains why you need the item or service, or why you otherwise disagree with our decision. Call your provider if you need this information.
* Your request to continue services, if applicable (please refer to the “Continuation of services during the appeal process” section below).

We recommend keeping a copy of everything you send us for your records.

## If you want someone else to act for you

If you want someone that is not the doctor or other provider that requested this service to act on your behalf for the appeal, you must make this statement in writing. You’ll need to mail or fax this statement to us. Keep a copy for your records.

# What happens next?

If you ask us for an appeal, we will follow the appeal processes for both Medicare and Medicaid. Your appeal will be evaluated based upon the information that you provided to us. If you prefer to present your case in person, indicate that when making your appeal request to us. You will still need to submit, in writing, any evidence you want us to consider.

We will give you our answer within [*insert appropriate timeframe for medical service/item or Part B drug:* **15 calendar days**, **7 calendar days**] after we get your appeal. [*May delete if the notice is for a denial of payment:* If you qualify for a fast appeal, we will give you our answer within 72 hours.] However, if you or your provider asks for more time or if we need to gather more information, we may take up to 14 more calendar days.

# What if we deny your Level 1 Appeal?

If we deny your appeal to us, it will be automatically forwarded to the Medicare Independent Review Entity (IRE) for another review. You will be notified when this happens. You can also ask for a Medicaid State Hearing if we deny your appeal. Refer to the section below for more information about how to ask for a Medicaid State Hearing.

## How to ask for a Medicaid State Hearing

You can **only** ask for a Medicaid State Hearing after you have appealed to our health plan and received a written decision with which you disagree. To ask for a Medicaid State Hearing, you must follow the directions on the Right to a State Hearing form that we will include with our written decision on your Level 1 appeal. You must ask for a State Hearing within **120 calendar days** of our written decision on your Level 1 appeal. [*If the action is the denial of payment for a service not covered by Medicaid, plans must include the following:* If you are being billed because we denied payment for a service, it is important to call us at <plan phone number> (TTY: <plan TTY number>). We can assist you with the provider, and if the provider does not agree to stop billing you, give you information on how to ask for a State Hearing.]

## If you want someone else to act for you

If you want someone to act on your behalf for the appeal, you must make this statement in writing. You’ll need to mail or fax this statement to the Bureau of State Hearings. Keep a copy for your records.

## What happens next?

State Hearings are conducted by a hearing officer from the Bureau of State Hearings within the Ohio Department of Job and Family Services. The hearing officer’s decision will be provided in writing to you and your authorized representative. State Hearing decisions are usually given no later than 70 calendar days after you ask for a State Hearing. If you or your authorized representative asks for a fast decision and the Bureau of State Hearings agrees that expedited resolution is required, the decision will be issued within three working days from the date of the hearing request.

[*Plans may opt to include this section, but must always include it if the action is prior notice about a reduction, suspension, or termination of a service*:

# Continuation of services during the appeal process

If you ask us for an appeal because we decided to change or stop a service you were authorized to receive, you may be able to continue the service while your appeal is processing. In order to qualify, you must ask us to continue your services within **15 calendar days** from the mailing date of this notice or before the intended effective date of the action, whichever is later. If you meet that deadline, you can continue to get the service until one of the following happens:

* You withdraw your appeal; or
* Both the plan and the IRE deny your appeal.

Also, if we deny your appeal and you decide to ask for a State Hearing, you may be able to continue the service while the State Hearing is processing. In order to qualify, the Bureau of State Hearings must receive your request within **15 calendar days** from the mailing date of our appeal decision or before the intended effective date of the action, whichever is later.

Please note you are **not** entitled to continuation of services when:

* You have not yet started receiving the authorized service.
* You received the service that was authorized and you are appealing a denial of a new request.]

# Access to documents

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

# Get help & more information

* **<Plan name>**: If you have any problems reading or understanding this information, please contact <plan name> Member Services at <toll free phone and TTY numbers> for help at no cost to you. We can help to explain the information or provide the information orally, in English or in your primary language. We may have this information printed in certain other languages or in other ways. If you are visually or hearing-impaired, special help can be provided.
* **MyCare Ohio Ombudsman**: You can also contact the MyCare Ohio Ombudsman for help or more information. The ombudsman staff can talk with you about how to make an appeal and what to expect during the appeal process. The MyCare Ohio Ombudsman is an independent program, and the services are free. Call 1-800-282-1206 (TTY Ohio Relay Service: 1-800-750-0750).
* **Medicare**: 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048)
* **Medicare Rights Center**: 1-800-333-4114
* **Legal Aid**: 1-866-LAW-OHIO
* [*If applicable, insert other state or local aging/disability resources contact information.*]

[*Optional: Plans may insert a signature block for the individual who made the coverage decision.*]

[*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 <toll-free phone and TTY numbers>, <days and hours of operation>. The call is free.