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

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]:

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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 [*Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support 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 name> to review our decision by asking us for a Level 1 Appeal.

**Level 1 Appeal:** Ask <health plan name> for a Level 1 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 a Level 1 Appeal with <health plan name>” for information on how to ask for a plan level appeal.

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| **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, you must ask for an appeal within 10 days** of the date of this noticeor before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. |

**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 Level 1 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:* **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 a Level 1 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:* 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. [*Insert as applicable:* You can also submit your appeal electronically.]

**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 a Level 1 Appeal and we continue to deny your request for [*insert, if applicable:* payment of] a service or item, 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 or item 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 or item is covered by Medicaid, you can ask for a Fair Hearing. Your written decision will give you instructions on how to request a Fair Hearing (information is also below).
* If the service or item could be covered by both Medicare and Medicaid, we will automatically send your case to the independent reviewer. You can also ask for a Fair Hearing.

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| How to ask for a Medicaid Fair Hearing  If your problem is about a service or item that could be covered by Medicaid or by both Medicare and Medicaid, you can ask for a Fair Hearing after we make our Level 1 Appeal decision.  Requests for a Fair Hearing are filed with <health plan name>. However, Fair Hearings are conducted by the Texas Health and Human Services Commission (HHSC) Appeals Division.  Step 1: You or your representative must ask for a Fair Hearing (in writing) within 120 days of the letter telling you we were denying your Level 1 Appeal to our plan. The HHSC Appeals Division can extend this deadline if you have a good reason for being late.  If we’re stopping or reducing a service, you can keep getting the service or item while your case is being reviewed. To qualify, you must ask for a Fair Hearing within 10 days of the date of the letter telling you we were denying your Level 1 Appeal to our plan or before the service is stopped or reduced, whichever is later.  Your written request must include:   * Your name * Address * Member number * Reasons for appealing * Any evidence you want the HHSC Appeals Division to review, such as medical records, doctors’ letters, or other information that explains why you need the service or item. Call your doctor if you need this information.   Step 2: Send your request to: [Insert address to mail fair hearing requests.]  Or you can call Member Services at <phone number>. We can help you with this request. If you need a fast decision because of your health, you should call Member Services to ask for an expedited Fair Hearing.  What happens next?  The HHSC Appeals Division will hold a hearing. You may attend the hearing in person or by phone. You’ll be asked to explain why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision within 90 days. The written decision will explain if you have additional appeal rights.  [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: <phone number> (TTY: <TTY number>), <hours of operation>. You can also visit our website at <plan website>.
* **HHSC Ombudsman’s Office**: You can also contact the HHSC Ombudsman’s Office 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 HHSC Ombudsman’s Office is an independent program and the services are free. Call 1-866-566-8989 (TTY: 1-800-735-2989).
* **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.
* **Medicaid**: 1-800-252-8263 (TTY: 1-800-735-2989)
* [*If applicable, insert other state or local aging/disability resources contact information*.]

[*Plan 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. [*Plans must provide the information in alternate formats when a Member requests it or when the plan identifies a Member who needs it.*]