[FIDA PLAN NAME/LOGO]

**Appeal Level:** **1**

**1 2 3 4**

**[*An Acknowledgement of Appeal notice must accompany this notice*]**

**We Cannot Give You a Fast (or “Expedited”) Appeal**

**Name: Date of Notice:**

**Participant Number:**

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

Dear <Participant name>,

On <date appeal received, orally or in writing,> at <hour received> you, or someone acting for you, asked for a fast (or “expedited”) appeal for the following action: [*Insert* *a* *brief description of the FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved.*]

**We denied your request for a fast appeal**

Your request for a fast appeal (also known as an “expedited” appeal) was denied because you did not prove that a standard appeal could seriously risk your life, health, or ability to function. The reasons for our decision are as follows: [*Insert specific rationale for the decision, and include any clinical rationale that explains why it was decided that the standard timeframe would not jeopardize the participant’s life, health or ability to regain maximum function or stay in their home or other residence. Also indicate that the Participant and his/her representative, if applicable, may request the relevant clinical review criteria at no cost to them.*]

**You may file a fast grievance**

If you think we made a mistake in denying your request for a fast appeal, you or someone acting for you can file a fast grievance (also known as an “expedited” grievance) to ask us to reconsider. We will respond to your grievance within 24 hours.

**Step 1 –** Gather your information and materials. You will need the following:

* Your name
* Your date of birth (or other identifying information, like your Participant number)
* Your contact information (for example: your phone or mailing address)
* Reason(s) why you need a fast appeal
* Any evidence or information that you want us to review to support your need for a fast appeal (for example: medical records, doctors’ letters, or other information that explains your need). Call your doctor or Care Manager if you need this information.

[*If the plan requires any specific information to address the grievance, insert the following text:*]

Please submit the following specific information to help us reach our decision on your grievance:

**Step** **2 –** Send the information and materials by mail, fax, or phone. You can also deliver it in person, or give it to your Care Manager. We recommend keeping a copy of everything for your records.

**Grievance Contact Information:**

Phone <phone number>

Regular Mail <address>

Fax <fax number>

Delivery in Person <address>

Contacting your Care Manager <phone number>

**You will have a standard appeal**

Because we denied your request for a fast appeal, you will have a standard appeal. This is Level 1 of the appeal process. Please refer to the “Acknowledgement of Appeal” notice enclosed with this letter to learn more about:

* The appeal review process
* How to ask for an in-person or phone-based review
* How to ask for transportation or an in-home review
* How to get your case file
* How to submit evidence
* How to choose a representative
* How to get free and independent information and advice about your case

Contact us immediately if you did not receive your “Acknowledgement of Appeal” notice, or if you have any questions about these topics.

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

[*Plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:*]

A copy of this notice has been sent to: <name>

<address>

<phone number>

**Get help & more information**

(TTY users call 711, then use the phone numbers below)

| * <Plan name>   Website: <plan website>  Toll Free Phone: <phone number>  TTY users call: <TTY number>  <days and hours of operation>   * Independent Consumer Advocacy Network (ICAN)   Website: <http://icannys.org>  Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  Toll Free Phone: 1-844-614-8800  8:00am – 8:00pm, Monday – Sunday | * 1-800-MEDICARE (1-800-633-4227)   TTY users call: 1-877-486-2048  24 hours a day, 7 days a week   * NYS Department of Health   Bureau of Managed Long Term Care  Toll Free Phone: 1-866-712-7197   * Medicare Rights Center   Toll Free Phone: 1-888-HMO-9050 |
| --- | --- |

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

ATTENTION: If you speak [*insert language of the disclaimer*], language assistance services, free of charge, are available to you. Call[*insert Participant Services toll-free phone and TTY/TDD 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.*]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Participant Services toll-free phone and TTY/TDD numbers and days and hours of operation*]. The call is free.

The State of New York has created a Participant Ombudsman Program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at [icannys.org](http://www.icannys.org). (TTY users call 711, then follow the prompts to dial 844-614-8800.)

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)*.*]