[FIDA PLAN NAME/LOGO]

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

**1 2 3 4**

**In-Person Appeal Review**

**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> [*for expedited appeals insert:* at <hour received>] you, or someone acting for you, appealed 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.*]

[*Insert* *for in-person review requests made with the appeal:* In your appeal you also asked for an in-person review.][*Insert if the request is made after the appeal is filed:* On <date of in-person review request>, you asked for an in-person review.] We are sending this notice to let you know that your in-person review has been scheduled for:

Date: <date (chosen after contact with Participant to discuss availability)>

Time: <time>

Location: <address>

If you need to reschedule, call <phone number>.

**Transportation to the in-person review**

[*Insert following paragraph if transportation was requested:*]

You asked for transportation to your in-person review. Your transportation request was [*insert as applicable*: granted *or* denied]. Call <phone number> for more information.

[*Insert following two paragraphs if transportation was not requested:*]

You, and any witnesses that may require it, are entitled to receive necessary transportation to and from the in-person review. If you are homebound, or if transportation could be harmful to your health or safety, make sure to ask that the review is conducted at your home or other residence.

<Plan name> will only provide transportation or an at-home review when necessary. It is important for you or your representative to give <plan name> an explanation for why transportation services are needed. You can ask for transportation services by calling us at: <phone number>. TTY users call <TTY number>.

**Filing a grievance**

If you have been unable to schedule the in-person review at a time or location (such as your home) that works for you, you may file a grievance. If we denied your transportation request, you may file a grievance. To file a grievance, follow these steps:

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

* Your name
* Address
* Participant number
* Reason(s) why you need to reschedule the review, need transportation to the review, or need an in-home review
* Any evidence or information that you want us to review to support your case, such as medical records, doctors’ letters, or other information that explains why you need to reschedule, need transportation, or need an in-home review. 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>

**The in-person review process**

[*Insert an explanation of the procedures for the plan’s in-person review. CMS and NYSDOH do not prescribe exact procedures, but you must at least tell the Participant that:*

* *He or she will be given an opportunity to argue their case on law and fact, submit evidence for review by the plan, and present witness testimony (either their own, or that of another—which may or may not be in-person), and*
* *That no person(s) involved with the in-person review was involved in the original plan action/IDT decision.*]

We will make a decision about your appeal by [*Insert date/time of appeal decision deadline (72 hours from receipt of appeal for fast appeals, 7 calendar days from receipt of appeal for standard Medicaid prescription drug appeals, 60 calendar days from receipt of appeal for reimbursement requests, and 30 calendar days from receipt of appeal for all other standard appeals)*]. [*Insert for expedited appeals:* We will try to contact you in person or by phone as soon as we decide your appeal.]

If you would like extra time to submit information to support your appeal, you can ask us to delay our decision by up to 14 more calendar days. Or, if we need to gather more information to decide your appeal, we can take up to 14 more calendar days to make our decision. If we take extra time, we will notify you in writing. If you believe we should not take more time to make a decision, you can file a fast grievance. We will respond to your grievance in 24 hours.

**Getting your case file and submitting evidence**

You have the right to get a copy of any documents from your case file with <plan name> that will help you show why our decision was wrong. You or your representative (if you have one) may ask for these documents, at no cost, by calling <phone number> or by fax to <fax number>.

If you would like us to consider any information before we make our decision, you should submit it **as soon as possible**. You do not have to wait until the in-person review, although we will accept it then as well. You can submit evidence or testimony **1)** over the phone, **2)** by mail or fax, [or] **3)** at your in-person review [*Insert if the plan has a drop-off location:* , or **4)** by hand delivery at our drop-off location before your review]. We recommend keeping a copy of everything for your records. Please submit evidence or testimony to:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

<Drop-off Address, if applicable>

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

Fax: <fax number>

**If you want someone to represent you**

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, attorney, or an ICAN staff member (see below).

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you haven’t already named someone to represent you and want to choose someone now, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. Send your written letter or form to us by fax or mail, or give it to your Care Manager. Keep a copy for your records. If you have any questions about naming your representative, such as what to say in your letter, call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the FIDA program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice, and may even represent you. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[*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)*.*]