[FIDA-IDD PLAN NAME/LOGO]

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

**1 2 3 4**

**Notice of Appeal Decision Delay**

**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, LP renewal, etc.) being appealed and the benefits involved.*]

[*Insert the following section if the Participant (or his/her representative) requested the extension:*]

**You asked us to delay our appeal decision**

You, or someone representing you, asked for more time before <plan name> makes its decision on your appeal. We got your extension request on <date>. You asked for more time because: [*Give a brief description of the Participant’s request. Include the reason or purpose of the extension (e.g. submitting documentation for review, obtaining specialist review of Participant medical condition, etc.), if known.*]

Due to this request, we extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. If you no longer want the extension, call <plan name> immediately at: <phone number>. TTY users call <TTY number>.

[*Insert the following section if the plan initiated the extension:*]

**We delayed our appeal decision**

We extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. We delayed the decision because: [*Explain why the decision was delayed. For example, the receipt of additional medical evidence from noncontract providers may be crucial to the appeal decision.*]

This delay is in your interest and is allowed by federal regulation. If you think this delay is inappropriate, read “You can file a fast grievance” below for information about your rights.

[*Insert the following section if the plan needs additional information from the Participant to decide the appeal:*]

**What we need from you**

To help us decide your appeal, please submit the following information or materials:[*Request any items from the Participant which may have prompted the delay, e.g. witness statements, non-network provider records, etc.*]

We recommend keeping a copy of everything for your records. Send the information or materials by mail, fax, or phone to:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

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

Fax: <fax number>

**You can file a fast grievance**

If you think we made a mistake by extending the appeal decision deadline, you or someone acting for you can file a fast grievance (also known as an “expedited” grievance). This will allow someone else at <plan name> to decide whether the extension is appropriate. We will respond to your grievance within 24 hours. Follow these steps to file a fast grievance.

**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 delaying the decision is not in your interest
* Any evidence or information that you want us to review to support why delaying a decision is not in your interest

[*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 a 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>

**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 have not 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 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-IDD 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.

[*The plan 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   * Medicare Rights Center   Toll Free Phone: 1-888-HMO-9050 | * 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   * NYS Office for People With Developmental Disabilities (OPWDD)   Toll Free Phone: 1-866-946-9733 |
| --- | --- |

[*Plan 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 (TTY users call 711, then follow the prompts to dial 844-614-8800) or online at [icannys.org](http://www.icannys.org/).

[*The plan is 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)*.*]