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 on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

{Replace *Denial of Medical Coverage* with *Denial of Payment*, if 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 {*payment of*} health care services/items listed below requested by you or your provider:

**Why did we deny your request?**

We {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} health care services/items listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

You should share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider requested coverage on your behalf, we have sent a copy of this decision to your provider.

**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 an appeal. Ask {health plan name} for an 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. See section titled “How to ask for an appeal with {health plan name}” for information on how to ask for a plan level appeal.

|  |
| --- |
| ***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 notice**or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your appeal, you may have to pay for these services.* |

**If you want someone else to act for you**

You can name a relative, friend, attorney, provider, or someone else to act as your representative. If you want someone else to act for you, call us at: {number(s)} to learn how to name your representative. TTY users call {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 appeals with {health plan name}** {This heading should be deleted if the notice is for a denial of payment and the Fast Appeal section below is deleted as well.}

**Standard Appeal –** We’ll give you a written decision on a standard appeal within **30 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 service you’ve already received, we’ll give you a written decision within **60 calendar days**.

{May be deleted 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 provider believe your health could be seriously harmed by waiting up to 30 calendar days for a decision.*

***We’ll automatically give you a fast appeal if a provider asks for one for you or if your provider supports your request.*** *If you ask for a fast appeal without support from a provider, 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 30 calendar days.*}

**How to ask for an appeal with {health plan name}**

**Step 1:** You, your representative, or your provider must ask us for an appeal. Your request must include:

* Your name
* Address
* Member number
* Reasons for appealing
* {May be deleted 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 be deleted 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 provider 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 see 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.

**For a Standard Appeal:** Mailing Address: {In Person Delivery Address:}

Phone: TTY Users Call:

Fax:

{Insert, if applicable: *If you ask for a standard appeal by phone, we will send you a letter confirming what you told us*.}

{May be deleted if the notice is for a denial of payment:

***For a Fast Appeal:*** *Phone: TTY Users Call:*

*Fax:* }

**What happens next?**

If you ask for an appeal and we continue to deny your request for {*payment of*} a service, 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 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 is covered by Medicaid, you can ask for a State Fair Hearing. You may also ask for an External Review. Both the State Fair Hearing and the External Review are conducted by independent entities that are not part of the plan. Your written decision will give you instructions on how to request a State Fair Hearing and an External Review.
* If the service could be covered by both Medicare and Medicaid, we will automatically send your case to the independent reviewer. You can also ask for a hearing with the State Fair Hearing office or a RI External Review organization. Your written decision will give you instructions on how to request either or both of these appeal processes.

**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}.
* RIPIN Healthcare Advocate: You can also contact the RIPIN Healthcare Advocate 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 RIPIN Healthcare Advocate is an independent program and the services are free. Call 1-855-747-3224, Monday through Friday, 8:00 a.m.-5:00 p.m. and Thursdays, 8:00 a.m.-7:00 p.m.
* Medicare: 1-800-MEDICARE (1-800-633-4227 or TTY: 877-486-2048), 24 hours a day, 7 days a week
* Medicare Rights Center: 1-888-HMO-9050
* Elder Care Locator: 1-800-677-1116 or [www.eldercare.gov](http://www.eldercare.gov) to find help in your community.
* The POINT: 1-401-462-4444 (TTY: 711), Monday, Wednesday and Friday, 8:30 a.m.-4:00 p.m. and Tuesdays and Thursdays 8:30 a.m.-8:00 p.m.
* Rhode Island Department of Human Services Information Line: 1-855-MY-RIDHS (1-855-697-4347)
* {If applicable, other state or local aging/disability resources contact information}

{Plan must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidelines 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 Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation}. The call is free. {This disclaimer must be included in Spanish and 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. Please call {member services} at {toll-free number}, {days and hours of operation}. TTY users should call {TTY number}. The call is free.

{Plan must also describe how members can make a standing request to get materials, now and in the future, in a language other than English or in an alternate format.}

{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>.}