<Plan Name> Notice of Adverse Action

**Denial of Level 1 Appeal**

**Date: Member number:**

**Name:**

**Service:**

**{*Insert as applicable:* Authorization *or* Payment} Requested:**

**The Level 1 Appeal was denied**

We’ve {denied *or* partially denied} the Level 1 Appeal for {the payment of} services/items listed above. Our decision is:

**Why did we deny your Level 1 Appeal?**

We {denied *or* partially denied} the Level 1 Appeal above because {*include citation State or Federal law and regulation. You may also include Evidence of Coverage/Member Handbook 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 for a review of our decision by asking for a Level 2 Appeal (sometimes called an external appeal). A Level 2 Appeal is done by an independent organization that is not connected to the plan. MassHealth’s Level 2 Appeal organization is called the MassHealth Board of Hearings. You can ask to see the medical records and other documents used to make our Level 1 Appeal decision anytime before or during the Level 2 Appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**You can ask the MassHealth Board of Hearings to review our decision to deny your Level 1 Appeal.** You must make your request within **120 calendar days** of the date at the top of this notice.

If you are appealing because we planned to reduce or stop a service you currently get, you have the right to keep getting the service during the review by the Board of Hearings. **If you want the service to continue, you must ask for a Level 2 Appeal from the Board of Hearings within 10 days of the date at the top of this notice.**

**If you want someone else to request a Level 2 appeal for you**

You can name a relative, friend, attorney, health care provider, or someone else to make an appeal for you. You must tell us who you want to make the appeal for you on the Fair Hearing Request form attached to this notice.

**There are two kinds of Level 2 Appeals**

**Standard Appeal –** The Board of Hearings must give you a written decision on a standard appeal within **30 calendar days** after it gets your appeal. If the Board of Hearings needs to gather more information that may help you, it can take up to 14 more calendar days.

**Fast (Expedited) Appeal** – The Board of Hearings must give you an answer within **72 hours** of when it gets your appeal. If the Board of Hearings needs to gather more information, it can take up to 14 more calendar days. If you had a fast appeal at Level 1, you will automatically get a fast appeal at Level 2. You can also ask for a fast appeal if you or your health care provider believe your health, life, or ability to regain maximum function may be put at risk by waiting up to 30 calendar days for a decision. If you don’t qualify for a fast appeal, the Board of Hearings will give you a decision within 30 calendar days.

**How to make a Level 2 Appeal to the MassHealth Board of Hearings**

You, or your authorized representative, including your health care provider acting on your behalf, must ask for a Level 2 Appeal within **120 calendar days** of the date at the top of this notice.

**Step 1:** Complete the Fair Hearing Request Form that is attached to this notice. You can also get the form:

* Online in English or Spanish at: <https://www.mass.gov/service-details/masshealth-member-forms>.
* By calling MassHealth Customer Service at 1-800-841-2900, TTY 1-800-497-4648 (for people who are deaf, hard of hearing, or speech disabled).

**Step 2:** Make a copy of this notice.

**Step 3:** Send the completed Fair Hearing Request form and the copy of this notice to the MassHealth Board of Hearings. You can:

* Mail to: Board of Hearings, Office of Medicaid, 100 Hancock Street, 6th Floor, Quincy, MA 02171, or
* Fax to: 617-847-1204.

**What happens next?**

The Board of Hearings will schedule a hearing. When the hearing is completed, the Board of Hearings will send a written decision on your Level 2 Appeal.

* If the Board of Hearings says “yes” to part or all of what you asked for, we must approve the service for you, per that decision, within 72 hours.

* If the Board of Hearings says ”no” to what you asked for, it means they agree with the Level 1 Appeal decision. The letter you get will tell you that you can appeal to the Commonwealth of Massachusetts Superior Court.

**Get help & more information**

* <**Plan name**>: If you need any 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>.

* **My Ombudsman**: If you need more help or information, you can also contact My Ombudsman. My Ombudsman is an independent program. My Ombudsman staff can talk with you about how to make an appeal and what to expect during the appeal process. My Ombudsman services are free. Here are the ways to get help from My Ombudsman:
  + Call 1-855-781-9898, Monday through Friday from 9:00 a.m. to 4:00 p.m. People who are deaf, hard of hearing, or speech disabled should use MassRelay at 711 to call 1-855-781-9898.
  + Email [info@myombudsman.org](mailto:info@myombudsman.org)
  + Write to or visit the My Ombudsman office at 11 Dartmouth Street, Suite 301, Malden, MA 02148
    - Visit by appointment, or
    - During walk-in hours:
      * Mondays: 1:00 p.m. - 4:00 p.m.
      * Thursdays: 9:00 a.m. - 12:00 p.m.
  + Visit My Ombudsman online at [www.myombudsman.org](http://www.myombudsman.org)
* **Medicare**: 1-800-MEDICARE (1-800-633-4227 or TTY: 1-877-486-2048)
* **Medicare Rights Center**: 1-888-HMO-9050 (1-888-466-9050)
* **MassHealth Customer Service**: 1-800-841-2900 (TTY: 1-800-497-4648)
* {*If applicable, insert 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 any other* 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 Member Services toll-free phone and TTY/TDD numbers, and days and hours of operation*]. The call is free.

[*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).]