**APPEAL DECISION NOTICE (Aging Waiver Services)**

If you speak Spanish, 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.*]

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

**<<today\_date\_mmmm\_ddyyyy>>**

**<<r\_full\_name>>**

**<<r\_full\_address>>**

Re: Member Name **<<m\_full\_name>>**

Member ID No. **<<m\_external\_id>>**

Tracking Number **<<Event or Referral number under which denial was issued>>**

Dear **<<Name>>**:

We have reviewed the appeal received on **<<date>>** for the **<<denial, reduction, suspension, or termination>>** of **<<medical service/treatment>>**. **<<Clearly document the reason for the appeal>>**.

A <Plan Name> **<Medical Director or External Physician Consultant or Registered Nurse>** reviewed your appeal. **[If medical necessity denial, include the following:** The reviewer, **<reviewer name and title>**,is board certified in **<Specialty>**.**]**

After review of the information, we decided to **<<deny, suspend, reduce, or terminate>>** the service for **<<medical service/treatment>>**.

The reason for the decision is **<<explanation for the determination including the actual benefit, provision, guideline, protocol or other criterion on which the appeal decision was based and any alternative treatment>>**.

You can obtain free of charge any document, record, clinical criteria or other information relevant to your case by submitting your request to **<Member services>** at **[address and/or phone]><address><7702x-xxx-xxx-xxxx>** (TTY/TDD: **<xxx >**) **<days/hours of operation>**. The call is free.

This decision is not intended to limit your care. Your treatment choices are between you and your provider.

If you do not agree with this decision, you can ask for a State Fair Hearing. This must be requested within **one hundred and twenty (120) calendar days** of the date of this letter. If you want your services to remain in place during the State Fair Hearing process, you must say so when you appeal, and you must ask for a State Fair Hearing within **ten (10) calendar days** of the date of this letter.

You can ask for a State Fair Hearing in one of the following ways:

Mail: Illinois Department of Healthcare and Family Services

Bureau of Administrative Hearings

69 West Washington Street, 4th Floor

Chicago, IL 60602

Fax: 312-793-2005

Email: HFS.FairHearings@Illinois.gov

Call: 855-418-4421 (TTY users call: 800-526-5812)

**[Insert when online submission becomes available:**

Online: Visit [https://abe.illinois.gov/abe/access/appeals](https://abe.illinois.gov/abe/access/appeals%20) to set up an ABE Appeals Account and submit a State Fair Hearing request online. This will allow you to track and manage your appeal online, view important dates and notices, and submit documentation.**]**

Filing a request for a State Fair Hearing will not adversely affect you or your benefits. Please see your Member Handbook for more information on the State Fair Hearing process.

You can also contact the Illinois Home Care Ombudsman (HCO) Program for help or more information. A HCO is an advocate that can talk with you about the State Fair Hearing and what to expect during the hearing process. HCO program is independent and the services are free. Here are ways that you can get help from a HCO:

* Call 1-800-252-8966 (TTY: 1-888-206-1327). Hours are Monday through Friday from 8:30 a.m. to 5:00 p.m.
* Email Aging.HCOProgram@illinois.gov

Sincerely,

<Medical Director>

<plan name>

Cc: **<<facility\_name>>**

**<<pcp\_full\_name>>**

**<<treating provider name>>**

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

[*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)*.*]