**APPEAL DECISION NOTICE (DRS 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 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 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 have decided to **<<deny, suspend, reduce, or terminate>>** the service for **<<or payment of>> <<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: **<xxx>**) **<days/hours of operation>**.

You, your doctor, or someone that you name to act for you, including an attorney, can help you with this request for information or with your case generally. If you want help, 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.

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 **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. If you do not win this appeal, you may be responsible for paying for the services provided to you during the appeal.

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

Mail: Illinois Department of Human Services

Bureau of Hearings

69 West Washington Street, 4th Floor

Chicago, IL 60602

Fax: 312-793-8573

Email: [DHS.HSPAppeals@Illinois.gov](mailto:DHS.HSPAppeals@Illinois.gov)

Call: 800-435-0774 (TTY users call 877-734-7429)

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

Online: Visit <https://abe.illinois.gov/abe/access/appeals> 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.
* [Aging.HCOProgram@illinois.gov](mailto:Aging.HCOProgram@illinois.gov)

Sincerely,

<Medical Director>

<plan name>

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

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

**<<treating provider name>>**

[*Plan 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)*.*]