

Coverage Decision Letter

[IMPORTANT: For help with this notice, contact <Plan Name> at <Plan customer service phone number> (TTY: <TTY number>) OR <Ombudsman or other program office> at <phone number> (TTY: <TTY number>)]

<Date of Letter>

[Insert Member name]

Member Health Plan ID:

Service/item this letter is about:

[Insert additional field(s) as needed or when required by state, such as provider or Member Medicaid ID or date of decision]

<Plan name> is called “our plan” or “we” in this letter. We are a health plan that contracts with Medicare and Medicaid *[Replace with state-specific term for Medicaid, if applicable]* to provide coverage for both programs. Our plan coordinates your Medicare and Medicaid *[Replace with state-specific term for Medicaid, if applicable]* services and your doctors, hospitals, pharmacies, and other health care providers.

Our plan <denied or partially approved or reduced or stopped or suspended or changed> *[Insert if applicable: payment for]* the <medical service/item or Medicare Part B drug or Medicaid drug> listed below:

[Insert description of medical service/item or Medicare Part B drug or Medicaid drug, including the amount, duration, and scope, of what the enrollee requested (e.g., physical therapy visits 2 times per week for 1 year), and the outcome, denied, partially approved, reduced, stopped, suspended, or changed, and include the doctor or provider’s name if a particular doctor or provider requested the service or item. If a service or item request is partially approved, reduced, or changed, include specifically what was requested and what is approved (e.g., We are approving acupuncture services for 3 months instead of a full year, or We are approving moving a toilet to the south wall instead of the east wall of the bathroom, or We previously approved 18 acupuncture visits per year but are now reducing the visits to only allow 10.)]

*[Insert if this is a post-service case for which there is no member liability: **Please note, you will not be billed or owe any money for this** [insert as applicable: **medical service/item or Medicare Part B drug or Medicaid drug**].]*

Our plan made this decision because *[Provide a specific denial reason and a concise explanation of why the medical service/item or Medicare Part B drug or Medicaid drug was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision in plain language. The plain language explanation*

of the decision should include: (1) relevant context for the decision (e.g., if the medical service/item or Medicare Part B drug or Medicaid drug was approved for the enrollee in the past, the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now); (2) coverage information considered including Medicare and Medicaid coverage benefits; and, (3) if applicable, information on how or why the requested service or item is not supported by the enrollee's needs – see instructions for more information].

*[Insert if denial will result in a stoppage, suspension, or reduction of a medical service/item or Medicare Part B drug or Medicaid drug the individual has already been receiving: **Our plan will <reduce or stop or suspend> your <medical service/item or Medicare Part B drug or Medicaid drug> on <effective date>.** See the “How to keep getting your <medical service/item or Medicare Part B drug or Medicaid drug> during your appeal” section later in this letter for information about continuing to receive your <medical service/item or Medicare Part B drug or Medicaid drug> during your appeal.]*

You have the right to appeal our decision

You can appeal our plan's decision. Share this letter with your <doctor *or* health care provider> and ask about next steps. If you appeal and our plan changes its decision, we may pay for the <medical service/item *or* Medicare Part B drug *or* Medicaid drug>.

You can also call <plan phone number for appeal requests> (TTY: <TTY number>) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your <doctor *or* health care provider> to help you decide if you should appeal.

You must appeal to our plan by *[Insert specific appeal filing deadline date in month, date, year format – 65 calendar days from date of letter. Insert deadline date in bold text]*. Our plan may give you more time if you have a good reason.

There are two kinds of appeals

Our plan has two kinds of appeals – standard appeals and fast appeals.

1. If you ask for a **standard appeal**, our plan will send you a written decision within *[for a Medicare Part B drug the enrollee has not yet received, insert: **7 calendar days** or for any other medical service/item, insert: **30 calendar days** or a shorter timeframe if required by the state]* **after we get your appeal.**
2. If you ask for a **fast appeal**, our plan will give you a decision within *[insert: **72 hours** or a shorter timeframe if required by the state]* **after we get your appeal.** You can ask for a fast appeal if you or your <doctor *or* health care provider> believe your health could be **seriously harmed** by waiting up to *[for a Medicare Part B drug, insert: **7 calendar days** or for any other medical service/item, insert: **30 calendar days** or a shorter timeframe if*

required by the state] for a decision. Our plan will **automatically** give you a fast appeal if your <doctor *or* health care provider> **asks for one for you** or if your <doctor *or* health care provider> **supports your request**. If you ask for a fast appeal without support from a <doctor *or* health care provider>, our plan will decide if you can get a fast appeal. If our plan doesn't approve a fast appeal, we'll give you a decision on your appeal within *[for a Medicare Part B drug, insert: 7 calendar days or for any other medical service/item, insert: 30 calendar days or a shorter timeframe if required by the state]*.

[Delete if the letter is for a denial of a Medicare Part B drug or if the state does not allow extensions: For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.]

How to appeal

You, someone you named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or your <doctor *or* health care provider> can appeal. You can contact our plan to appeal in one of these ways:

- **Phone:** Call <plan phone number for appeal requests> (TTY: <TTY number>)
- **Fax:** Send a fax to <plan fax number for appeal requests>
- **Mail:** Mail it to <plan mailing address for appeal requests>
- *[Insert if appropriate: In person: Deliver it to <plan in-person delivery address>]*

If you appeal in writing, keep a copy. If you call, we'll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

- Your name
- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with our plan
- The reason(s) you're appealing our decision
- If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
- Anything you want our plan to look at that shows why you need the <medical service/item *or* Medicare Part B drug *or* Medicaid drug>. For example, you can send us:
 - Medical records from your <doctor *or* health care provider>,

- Letters from your <doctor *or* health care provider> (such as a statement from your <doctor *or* health care provider> that says why you need a fast appeal), or
- Other information that says why you need the <medical service/item *or* Medicare Part B drug *or* Medicaid drug>

To get more information on how to appeal, call Member Services at <toll-free plan Member Services phone number> (TTY: <toll-free TTY number>). You can also find more information in our plan's *[insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses]*, *[plans may insert chapter and/or section reference, as applicable]*. An up-to-date copy of the *[insert Evidence of Coverage, Member or Enrollee Handbook, or other term plan uses]* is always available on our website at <web address> or by calling our plan.

*[Optional to delete this section if the decision relates to a medical service/item or Medicare Part B drug or Medicaid drug that has not been received by the enrollee under a previous authorization of the medical service/item or Medicare Part B drug or Medicaid drug: **How to keep getting your <medical service/item *or* Medicare Part B drug *or* Medicaid drug> during your appeal***

If you're already getting the <medical service/item *or* Medicare Part B drug *or* Medicaid drug> listed on the first page of this letter, you can ask to keep getting it during your appeal.

- **You must appeal and ask our plan to continue getting your <medical service/item *or* Medicare Part B drug *or* Medicaid drug> by *[Insert continuation of benefits request filing date in month, date, year format. Date will be the later of the following: (1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state) or (2) date the decision takes effect. Insert date in bold text]*.**
- See the "How to appeal" section earlier in this letter for information about how to contact our plan.
- If you ask our plan to continue your <medical service/item *or* Medicare Part B drug *or* Medicaid drug> by *[Insert continuation of benefits request filing date]*, your <medical service/item *or* Medicare Part B drug *or* Medicaid drug> will stay the same during your appeal.
- If your <doctor *or* health care provider> is filing the appeal for you and you want to keep getting your <medical service/item *or* Medicare Part B drug *or* Medicaid drug>, then your <doctor *or* health care provider> must include your written consent.]

What happens next

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies *[Insert if applicable: payment for]* the <medical service/item *or* Medicare Part B drug *or* Medicaid drug> listed on the first page of this Coverage

Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask <state name> for a Fair Hearing *[Insert if appropriate: (also called a <state-specific term for Fair Hearing>)]*.

What to do if you need help with your appeal

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your “representative” by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

- Call our plan at <plan phone number for representative requests> (TTY: <TTY number>) to learn how to name that person as your representative. Or, you can visit <https://www.medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me>. *[Plans may replace with a plan-specific web address that explains how enrollees can appoint a representative.]*

- You and your representative must sign and date a statement that says this is what you want.

- Mail or fax the signed statement to us at:

<plan address for representative requests>

<plan fax number for representative requests>

- Keep a copy.

Get help and more information

- **<Plan name> Member Services:** Call <toll-free plan Member Services phone number> (TTY: <toll-free TTY number>), <days and hours of operation>. You can also visit <plan website>.
- *[If the state uses an Ombudsman or other enrollee support program, insert the following language, with state-specific information here: <Name of program office>: Call <phone number> (TTY: <TTY number>). <Name of program office> can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren't connected with our plan or with any insurance company or health plan. Their services are free.]*
- **<Name of State Health Insurance Assistance Program (SHIP) office>:** Call <phone number> (TTY: <TTY number>). <Name of SHIP program> counselors can help you with Medicare issues, including how to appeal. <Name of SHIP program> isn't connected with any insurance company or health plan. Their services are free.

- **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit Medicare.gov.
- **<Medicaid/state Medicaid program name>:** Call <phone number> (TTY: <TTY number>).
- **Medicare Rights Center:** Call 1-800-333-4114, or visit www.medicarerights.org.
- **Eldercare Locator:** Call 1-800-677-1116, or visit www.eldercare.acl.gov to find help in your community.
- *[If applicable, insert other state or local aging/disability resources contact information.]*

You can get this document for free in *[Insert, as appropriate: <non-English language(s)> or]* 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.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit Medicare.gov/about-us/accessibility-nondiscrimination-notice, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1386. This information collection is for the coverage decision letter issued upon denial, in whole or in part, of an enrollee's request for an integrated organization determination and upon discontinuation or reduction of a previously approved authorization. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory per 42 CFR §§ 422.631 and 438.210. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ******CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Kristi Sugarman Coats at kristin.sugarman-coats@cms.hhs.gov.**