# Appeal Decision Letter

**<Date of Letter>**

[*Insert Member name*]

Member Health Plan ID:

Service/item this letter is about:

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

<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 denied>the appeal we got on <date appeal received> for the <service** *or* **item> listed above.**

Our plan made this decision because [*Provide a specific denial reason and a concise explanation of why the service/item was denied. Include citations of applicable state and federal rule, law, and/or regulation that support the decision. The plan may also include Evidence of Coverage/Member or Enrollee Handbook provisions and plan policies/procedures or assessment tools used to support the decision. Write the explanation in plain language and give, at a minimum, a basic explanation of the reasoning behind the action in the simplest language possible without losing meaning; do not include coding or technical terms, nomenclature, or other system-based or otherwise internal plan designations without appropriate explanation of the terms.*].

**Our plan will** [*include one of the following as applicable:*

**limit the number of <hours** *or* **days> authorized for your [*insert name of service or item*] to [*insert number of hours or days*] <hours** *or* **days>, effective [*insert effective date*].**

*or*

**reduce the [*insert name of service or item*] you’re getting from [*insert number of hours or days*] <hours** *or* **days> to [*insert number of hours or days*] <hours** *or* **days>, effective [*insert effective date*].**

*or*

**stop the [*insert name of service or item*] you’re getting, effective [*insert effective date*].**

*or*

**not cover [*insert name of service or item*].**

*or*

**[*insert explanation of action*], effective [*insert effective date*].**]

**You can appeal again**

If you appeal again, this is called a **Level 2 appeal**. Share this letter with your <doctor *or* health careprovider> and ask about next steps.

You can also 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 decide if you should appeal again.

**How the Level 2 appeal process works**

[*Insert one of the following sets of paragraphs as applicable:*]

[*Insert for a* ***Medicare-only*** *covered service or item:* You don’t need to do anything. Our plan will **automatically** send your case to the Medicare Independent Review Entity (IRE) for a Level 2 appeal. The IRE is an organization that isn’t connected to our plan. **The IRE will give you an answer within 30 calendar days from when it gets your appeal. In some cases, it may be sooner.**]

[*Insert for a* ***Medicaid-only*** *covered service or item:* You can ask the state of <state name> for a Fair Hearing. A Fair Hearing agency not connected to <plan name> will review your case.

* Ask for a Fair Hearing by [*Insert state-specific instructions for Medicaid State Fair Hearings, including the information that members should submit, dates and timelines for submission, information on naming a representative, methods that members can use to request a State Fair Hearing (written, telephone, etc.), and who to contact for questions about the process. Also include key dates in bold and instructions for requesting expedited appeals if applicable. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*].
* If you ask for a Fair Hearing, [insert state-specific process information here about what happens when a member requests a State Fair Hearing. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible)].]

[*Insert if the state has an external review process and the service or item appealed is appropriate for the state external review:* In <state name>, you can also ask for a <name of state external review>. Again, an organization not connected to <plan name> will review your case. [*The plan may insert a description of how a state external review differs from a State Fair Hearing. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*]

* Ask for a review by <name of state external review entity>by [*Insert state-specific instructions for external review entity if applicable, such as the information that members should submit, dates and timelines for submission, information on naming a representative, methods that members can use to request an external review entity (written, telephone, etc.), and who to contact for questions about the process. Also include key dates in bold and instructions for requesting expedited appeals if applicable. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*].
* If you ask for a review by <name of state external review entity>, [*insert state-specific process information here about what happens when a member requests a state external review. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible)*].]

[*Insert for a service or item covered by* ***both Medicare and Medicaid****:* The <service *or* item> listed on the first page of this letter can sometimes be covered by both Medicare and Medicaid [*Replace with state-specific term for Medicaid, if applicable*]. Our plan doesn’t review Level 2 appeals. So, two different organizations not connected to <plan name> can review your case. Their reviews can happen at the same time:

* **The Medicare Independent Review Entity (IRE).** Because Medicare may cover your <service *or* item>, our plan will **automatically** send your case to the Medicare IRE for a Level 2 appeal. **The IRE will give you an answer within 30 calendar days from when it gets your appeal. In some cases, it may be sooner.**
* **The state of <state name>.** Because Medicaid [*Replace with state-specific term for Medicaid, if applicable*] may cover your <service *or* item>, you can also ask the state of <state name> for a Fair Hearing. A Fair Hearing agency not connected to <plan name> will review your case.
	+ Ask for a Fair Hearing by [*Insert state-specific instructions for Medicaid State Fair Hearings, including the information that members should submit, dates and timelines for submission, information on naming a representative, methods that members can use to request a State Fair Hearing (written, telephone, etc.), and who to contact for questions about the process. Also include key dates in bold and instructions for requesting expedited appeals if applicable. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*].
* If you ask for a Fair Hearing, [Insert state-specific process information here about what happens when a member requests a State Fair Hearing. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).].]

[*Insert if the state has an external review process and the service or item appealed is appropriate for the state external review:* In <insert state name>, you can also ask for a <name of state external review>. [*The plan may insert a description of how a state external review differs from a State Fair Hearing. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*].

* Ask for a review by <name of state external review entity>by [*Insert state-specific instructions for external review entity if applicable, such as the information that members should submit, dates and timelines for submission, information on naming a representative, methods that members can use to request an external review entity (written, telephone, etc.), and who to contact for questions about the process. Also include key dates in bold and instructions for requesting expedited appeals if applicable. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible).*].
* If you ask for a review by <name of state external review entity>, [*Insert state-specific process information here about what happens when a member requests a state external review. The text must be in plain language and must be in the form of a description or statement written to be understandable to a layperson (to the extent possible)*].]

To get more information about a Level 2 appeal, call <Plan phone number for appeal requests> (TTY: <TTY number>) *or* 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*],[*p*lans 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.

**What happens to your <service** *or* **item> during your Level 2 appeal**

[*Insert one of the following sets of paragraphs as applicable:*]

[*Insert for a* ***Medicare-only*** *covered service or item:* You **won’t** keep getting this <service *or* item> through our plan during the Level 2 appeal process with the IRE.]

[*Insert for a service or item covered* ***by Medicaid or by both Medicare and Medicaid****:* You may be able to keep getting your <service *or* item> during your Level 2 appeal if both of these apply:

* You qualified to keep getting your <service *or* item> while our plan reviewed your first appeal.
* **You ask for a Fair Hearing** **by [*insert specific State Fair Hearing filing date in month, date, year format – 10 calendar days from the date of letter or other timeframe required by the state. Insert deadline date in bold text*].**]

If your <service *or* item> continues during your Level 2 appeal, you can keep getting the <service *or* item> until one of the following happens:

* You withdraw the appeal; or
* All of the organizations that got your appeal deny it.

[*Insert if the state allows for recovery of costs incurred during the State Fair Hearing process when the State Fair Hearing decision is adverse to the enrollee:* If you ask for a Fair Hearing and ask to keep getting the <service *or* item> during the Fair Hearing:

* **You won’t have to pay** for the <service *or* item> you have already gotten while our plan reviewed your appeal.
* **Our plan must pay** for the <service *or* item> you got during the Fair Hearing process if you win your Fair Hearing.
* **You may have to pay** for the <service *or* item> you got during the Fair Hearing process if you lose your Fair Hearing.
* [*Insert any other state-specific information about recovery of costs during the State Fair Hearing stage*]*.*]

**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 member 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 questions if you have a problem with your appeal. They can also help you understand what to do next. <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](http://www.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](http://www.medicarerights.org/).
* **Eldercare Locator:** Call 1-800-677-1116, or visit [www.eldercare.acl.gov](https://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 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.

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, visit* <http://www.hhs.gov/civil-rights/for-individuals/section-1557>.]