**DECISION ON YOUR REQUEST FOR AN APPEAL**

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| **Notice Date:** [INSERT DATE] | | **Trackable Mail #:** [INSERT NUMBER] | | **PA #:** [INSERT PA NUMBER] | |
| **This Action will take effect on:** [INSERT EFFECTIVE DATE] | | | **Call** [VENDOR HELP LINE] **for help** | | |
| [MEMBER NAME or LEGAL GUARDIAN]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  [CITY, STATE, ZIP] | | | [REQUESTOR NAME/ADDRESS]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  [CITY, STATE, ZIP] | | |
| **MID:** [MEMBER MID] | [UNIQUE PLAN ID] | | **Member:** [NAME] | | **DOB:** [MEMBER DOB] |
| [PHP NAME] manages your Medicaid services. On [DATE OF ORIGINAL REQUEST], you or your provider asked us to approve your request for a health service or item. | | | | | |
| On [DATE OF ORIGINAL DECISION], we made a decision to Choose an item. On [DATE OF REQUEST FOR APPEAL] you asked us to change that decision. | | | | | |
| **We have decided** Choose an item. | | | | | |
| **THIS DECISION CHANGES SERVICES YOU ARE ALREADY RECEIVING.**  **IF YOU DON’T AGREE WITH THIS DECISION, YOU CAN APPEAL IT.**  **READ THE INSTRUCTIONS IN THIS NOTICE CAREFULLY AND ASK US FOR HELP IF YOU NEED IT.**  This letter tells you about our decision. Please read it carefully.  To appeal this decision, you must ask us for a **State Fair Hearing.**  To ask for an appeal, fill out and send us your State Fair Hearing Request form. You will find it in this notice.  The last day to ask for a State Fair Hearing is [INSERT 120th DAY FROM DATE ON NOTICE. IF 120th DAY IS A HOLIDAY OR WEEKEND INSERT DATE FOR THE NEXT BUSINESS DAY]. You have 120 days from the date on this notice to ask for a State Fair Hearing.  If you want your services to stay the same during your appeal, you must appeal by [INSERT 10th DAY AFTER DATE ON NOTICE].  If you need help filing your appeal, call us at [PHP phone number]. | | | | | |

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| **YOU WERE RECEIVING:** | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | **Approved Amount** |
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| **On [DATE OF ORIGINAL DECISION], we** Choose an item. | | | | | |
| **AFTER YOUR APPEAL, WE APPROVED:** | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | **Approved Amount** |
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| **AFTER YOUR APPEAL, WE ARE STILL DENYING:** | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Denied Dates** | **Denied Amount** |
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| **COMMENTS**:  [PHP DEFINED FREE TEXT AVAILABLE] | | | | | |
| **For Members Under 21 Years of Age:**  Federal law requires us to cover most medical treatments and services for members under 21 years old. We will never deny a service request before we review it by Federal *Medicaid Act* standards. (These standards are known as “EPSDT medical necessity criteria”). Policy requirements or limits for adults over age 20 do not apply in these cases.  In this section you’ll see **both** the state policies *and* the federal EPSDT criteria that were used in making this decision. | | | | | |
| DD 1: **We asked your provider to send us more information to help us approve your request. Your provider didn’t send us the information.**   * On [DATE OF REQUEST FOR ADDITIONAL INFORMATION], we asked your provider for the following important facts or documents:   [BRIEF FREE TEXT STATEMENT ON ADDITIONAL INFORMATION REQUESTED].   * Without this additional information, your request did not meet criteria for approval found in [IDENTIFY POLICY HERE].   **For members under 21 years of age:**  We must review your request by federal EPSDT criteria to approve it. These criteria require that a requested service be effective and safe to treat a child’s medical condition and problems. These decisions are made on a case-by-case basis. Without this additional information, we cannot be sure that the service you requested meets these requirements. | | | | | |
| DD 2: **We denied your request for:**   * [CODE] [SERVICE DESCRIPTION]:   **Medicaid Health Plan policy rules found at [STATE SECTION AND POLICY NAME HERE] guided our decision.**  Here are the policy requirements your request did not meet:  [BRIEF POLICY CITATION IN FREE TEXT] | | | | | |
| DD 2: **We denied your request for:**   * [CODE] [SERVICE DESCRIPTION]:   **Your provider didn’t send us information we requested.**   * On [DATE OF REQUEST FOR ADDITIONAL INFORMATION], we asked your provider for the following important facts or documents:   [BRIEF FREE TEXT STATEMENT ON ADDITIONAL INFORMATION REQUESTED].   * Without this additional information, your request did not meet criteria for approval found in [GENERAL POLICY NAME HERE].   **For members under 21 years of age:**  We must review your request by federal EPSDT criteria to approve it. These criteria require that a requested service be effective and safe to treat a child’s medical condition and problems. These decisions are made on a case-by-case basis. Without this additional information, we cannot be sure that the service you requested meets these requirements. | | | | | |
| DD 3: **North Carolina Medicaid does not cover the following service(s) in our State Medicaid Plan:**  [CODE] [SERVICE DESCRIPTION]. | | | | | |
| **For members under 21 years of age, further review under federal EPSDT criteria was completed.**  [INSERT VENDOR NAME] found the following federal EPSDT criteria unmet for your request:  EPSDT Option 1: **The federal** **Medicaid program does not cover this service:**  [CODE] [SERVICE DESCRIPTION]  The service you’ve requested isn’t included in Medicaid’s coverable categories at §1905(a), Social Security Act.  EPSDT Option 2: **Your request is for an experimental or investigational treatment. It** **hasn’t been approved in medical practice for the use intended by your provider.**  [CODE] [SERVICE DESCRIPTION]  [PROVIDE BRIEF STATEMENT].  EPSDT Option 3: **The member’s individual health condition was reviewed. Reasonable standards of medical and dental practice were applied in this review. Your provider didn’t show that this service would be effective to:**   * **Improve your health condition;** * **Maintain your health in best condition possible;** * **Prevent your health condition form worsening;** * **Prevent the development of more health problems.**   [CODE] [SERVICE DESCRIPTION]:   * Your provider didn’t show that this service would be effective to help with your medical condition. [PROVIDE BRIEF EFFECTIVENESS or STANDARD OF CARE STATEMENT]. * There are equally effective and less costly treatments for your medical condition.   [PROVIDE BRIEF STATEMENT ON OTHER TREATMENT(S)].   * This service hasn’t been proven safe for treatment of your health condition**.**   [PROVIDE BRIEF SAFETY STATEMENT].  **For more information on EPSDT’s ‘correct or ameliorate’ standard, see the ‘EPSDT’ section of this Notice.** | | | | | |
| **Authority Supporting Decision:**  We base our decision to approve or deny a request for Medicaid services on:   * **10A NCAC 25A .0201: MEDICAL SERVICES** All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants. * The North Carolina State Plan for Medical Assistance, found at: <https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan> * Medicaid Clinical Coverage Policies found at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies> * [PHP POLICY WEBSITE]   If you don’t have internet access or want us to send you a free copy of any or all of these documents, please call [insert PHP help line telephone number]. We will mail the documents to you within five business days. | | | | | |
| **A full clinical rationale used in making this decision will be provided in writing upon request. To request a full rationale, call [PHP PHONE NUMBER].** | | | | | |

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| **EPSDT: Medicaid’s Benefit for Children Under 21 Years of Age:**  Medicaid’s children’s benefit is known as *“Early and Periodic Screening, Diagnostic and Treatment”* services, or EPSDT. For those under 21 years old, the EPSDT benefit requires us to cover any service available within the federal Medicaid Act *(42 U.S.C. §§ 1396(a)(10)(A))*, so long as it is medically necessary to ‘correct or ameliorate’ a physical or mental illness or condition. This means that the service is needed to:   * improve or maintain the child’s health in the best condition possible; OR * compensate for a health problem; OR * prevent it from worsening; OR * prevent the development of additional health problems.   When medically necessary, the requested service must be provided:   * even when it doesn’t appear on the list of plan benefits and; * in an amount, at times, and as frequently as needed, even if state or plan policy limits are exceeded. There is no limit on the number or visits or hours if medically necessary.   In addition, there is no waiting list to qualify for EPSDT services and there is no dollar limit on the amount of medically necessary EPSDT services that may be provided. EPSDT may require coverage of specialized services out of network or even out of state if specialized services are medically necessary and not available in-network or in North Carolina.  The services must be ordered by a physician, therapist, or other practitioner appropriately licensed to prescribe or deliver the requested service. For more information, see:  <https://medicaid.ncdhhs.gov/medicaid/get-started/find-programs-and-services-right-you/medicaids-benefit-children-and-adolescents>  See also the CMS publication; *“EPSDT-A Guide for States”,* found at: <https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf> |
| If you don’t have internet access or want to us to send you a free copy of any or all of these documents, please call [INSERT PHP HELP LINE TELEPHONE NUMBER]. We will mail the documents to you within five business days. |

**IF YOU DON’T AGREE WITH THIS DECISION, ASK FOR A STATE FAIR HEARING TO APPEAL IT**

**THIS DECISION WILL STOP OR REDUCE A SERVICE YOU RECEIVE RIGHT NOW.**

**IF YOU DO NOT APPEAL OUR DECISION, YOUR SERVICES WILL END ON** [LAST DAY OF OLD AUTHORIZATION].

* If you don’t agree with this decision, you may request a State Fair Hearing.
* You have a right to keep your service the same until your State Fair Hearing is finished.
* If you want the service you get now to stay the same as today until your State Fair Hearing is decided, you must send us your Fair Hearing Request Form before [INSERT LAST DAY OF OLD AUTHORIZATION HERE].
* To keep your services the same you must check the “Yes” box on the “**I want my services to continue”** line of your Form.

**What is happening to the service I have now?**

[INSERT PHP NAME] did not approve your new request for a service you receive now. The approval for the service you receive now ends on [INSERT LAST DAY OF OLD AUTHORIZATION HERE].

**What will happen if I send my Appeal Request form in after [INSERT LAST DAY OF OLD AUTHORIZATION]?**

You always have 120 days to Appeal the decision in this Notice. Medicaid will not pay for services you receive from the day your old approval ends on [INSERT LAST DAY OF OLD AUTHORIZATION HERE] until the day we get your Appeal Request Form.

**What will happen if my provider asked for less services in my new request?**

Sometimes, a provider may ask for fewer hours or amounts of your service than Medicaid approved in your old request. When this happens, youwill receive the hours or amounts that your provider asked for in the new request until your Appeal is decided. This will be less than the hours or amounts that were in Medicaid’s old approval.

**You have 120 days from the date of this notice to ask for a State Fair Hearing.**

**After 120 days, the decision in this notice is final.**

It is easy to ask for a State Fair Hearing by using one of the options below.

* **MAIL:** Fill out and sign the State Fair Hearing Request Form in this Notice. Mail it to the addresses listed on the form. OAH must receive your form no later than 120 days after the date on this notice.
* **FAX:** Fill out and sign the State Fair Hearing Request Form in this Notice. You will find the fax numbers listed on the form.
* **BY PHONE:** Call [INSERT PHP NAME] at [PHONE NUMBER] and ask for a State Fair Hearing. You will receive assistance to complete your form during this call.
* **ONLINE:** Visit your Health Plan’s website at [INSERT WEB ADDRESS HERE] and follow instructions there.

**HOW DO STATE FAIR HEARINGS WORK?**

The Mediation Network of North Carolina will call you within 5 business days after your form is received. During this call you will be offered a mediation meeting. Mediations are voluntary. If the mediation doesn’t solve your disagreement, you will have a State Fair Hearing. Your disagreement will be heard by a fair and impartial judge. You’ll get a decision within 5 days of your State Fair Hearing.

**ABOUT YOUR MEDIATION**

A member of the Mediation Network team will call you soon after your State Fair Hearing Request Form arrives. This helper will offer you a first meeting, called a ‘mediation’. This meeting is voluntary. You don’t have to use it. You may choose to have just a State Fair Hearing. Mediation meetings are led by a neutral person (a mediator) and a member of the [PHP NAME] team that reviewed your service request. A mediation can help to finish your appeal quickly. The mediator is professionally trained to hold problem-solving meetings. You don’t have to accept any offer made in mediation that is not right for you.

Mediation meetings are easy to attend. They are held by telephone for your convenience. You may also attend in person. A member of the [INSERT PHP] team that reviewed your service request will attend this meeting by phone. You may ask anyone to join you in the meeting, including your provider, a lawyer, a friend or a family member. Everyone must agree to their attendance. If you are happy with an offer made in this meeting, [INSERT PHP] can approve your services quickly. You won’t need to schedule your State Fair Hearing. If you miss your mediation without good cause, your appeal will be dismissed.

**YOU CAN GIVE NEW INFORMATION ABOUT YOUR MEDICAL CONDITION AT THE MEDIATION**

**New information about your medical condition is important.** Let the Mediation Center team member know if you have new information to share. During your first call you will learn how to send new documents.

**YOUR STATE FAIR HEARING**

If you don’t want a mediation meeting, or if you are not satisfied with the outcome of your mediation meeting, your mediator will ask for a State Fair Hearing for you. There is nothing else you need to do. All State Fair Hearings are conducted by an administrative law judge at the NC Office of Administrative Hearings (OAH). During your Fair Hearing, the judge will review your request and any additional information you provide. Usually, these Hearings are held by phone for your convenience. You can also request a video meeting. For a video meeting, you’ll need a computer set up with a camera and video programs. May also choose to be at your State Fair Hearing in-person. Hearings will be held at the OAH Wake County offices (Raleigh) unless you have a good reason why you cannot come to Wake County. If you miss your State Fair Hearing without good cause, your appeal will be dismissed.

**YOUR RIGHTS TO INFORMATION AND LEGAL REPRESENTATION IN FAIR HEARINGS**

You will receive a copy of the documents used to make the decision on your services before the day of your Hearing. You have the right to see your entire case file before the date of the Hearing. At the Hearing, you may give any new information, including medical records from doctors and other providers about your need for the requested services. You may speak for yourself during the Hearing. You may also bring an attorney or ask a relative or a friend to help. You may also ask your healthcare provider or a case manager to speak for you.

**YOUR STATE FAIR HEARING DECISION**

The administrative law judge conducting the State Fair Hearing will review evidence, hear testimony and will decide your appeal. You will receive this final agency decision by mail. If you disagree with the final State Fair Hearing decision, you can appeal the decision to the Superior Court, State of North Carolina in the county where you live. **You have 30 days from the day you receive your Fair Hearing Final Decision to appeal to the Superior Court.**

**IF YOU ASKED FOR A SERVICE YOU NOW RECEIVE TO CONTINUE UNTIL YOUR FAIR HEARING IS DECIDED**

You asked for a State Fair Hearing because Medicaid stopped or reduced a service you are getting now. If you asked for that service to continue until your Fair Hearing is finished there will not be an interruption in your service. You will receive the service until you have a decision. If the judge agrees with [PHP NAME]’s decision to reduce, deny or end your service, you may be required to pay for the services that were extended during your appeal.

**EXPEDITED STATE FAIR HEARINGS**

If you need a decision right away because you or your provider think that your life, your physical or mental health, or your ability to regain function is in danger, call your Plan’s Customer Support Team at [INSERT PHONE NUMBER]. Your Plan will help with your request. If your request for an expedited State Fair Hearing is approved, your appeal will be decided within 72 hours after we get your Form. If your request is denied, your hearing will be decided in the standard timeline. We will decide based on the information available to us at the time we review your request.

**IF YOU HAVE MORE QUESTIONS ABOUT YOUR STATE FAIR HEARING**

**[PHP] Help Line:**

[INSERT PHONE NUMBER]

**MEDIATION:**

Mediation Network of NC

336-461-3300

**HEARINGS:**

Office of Administrative Hearings:

919-431-3000

You may also contact Medicaid by calling the Department of Health and Human Services Customer Service Center toll-free at 1-800-662-7030, Monday-Friday 8:00-5:00. If you have questions for the North Carolina Medicaid Appeals team, please call **Division of Health Benefits Appeals Line:** 1-919-855-4350

**IF YOU NEED A STATE FAIR HEARING REQUEST FORM**

You can get a copy of the **Fair** **Hearing Request Form** by calling [INSERT PHP NAME] at: [INSERT PHONE NUMBER]

**FREE LEGAL AID MAY BE ABLE TO ASSIST WHEN YOU APPEAL A DECISION IN A FAIR HEARING**

* Contact your nearest **Legal Aid of North Carolina** office. If you need the telephone number of the office serving your community, call **1-866-219-5262 (toll-free).**
* If the beneficiary is a person with a disability, you may also contact **Disability Rights North Carolina** 1-919-856-2195 or 1-877-235-4210 (toll-free)

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| **Date:** [DATE OF APPEAL DECISION] | | **Decision made by:** [PHP] | |
| **COMPLETE THIS FORM AND FAX OR MAIL IT TO:** | | | |
| **Office of Administrative Hearings (OAH)**  **Attention: Clerk of Court**  **6714 Mail Service Center**  **Raleigh, NC 27699-6700**  **Fax: 919-431-3100** | | **[PHP NAME]**  **[ADDRESS LINE 1]**  **[ADDRESS LINE 2]**  **[CITY, STATE, ZIP]**  **[PHONE NUMBER]** | |
| [MEMBER OVER 21 OR LEGAL GUARDIAN]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  [CITY, STATE, ZIP] | | Name: [MEMBER NAME] | |
| MID: [MEMBER MID] | |
| **DIRECTIONS:** Please complete this form and mail or fax it to the Office of Administrative Hearings (OAH) and [PHP NAME] at the addresses or fax numbers listed above. **OAH** **must receive your completed form by** **[LAST DAY OF APPEAL PERIOD]***,* which is 120 days from the date of this notice. If you want your services to continue until your appeal if finished, you must check the box below. **OAH must receive your appeal within 10 days for your services to continue.** | | | |
| **I WOULD LIKE TO APPEAL [PHP NAME]’S DECISION ON MY REQUEST FOR****[SERVICES DENIED OR REDUCED]**. | | | |
| **I want my services to continue at the current level until my appeal is decided: □** YES **□** NO | | | |
| If you need a quick decision because your life, your physical or mental health, or your ability to regain function is in danger, ask for an Expedited Appeal by calling your health plan at: [INSERT PHONE NUMBER]. | | | |
| **□** I am requesting a free interpreter to assist during my appeal. My primary language is:  □ Español □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| You may represent yourself in the hearing process. You may hire an attorney or use a legal aid attorney. You may ask a relative, friend, or other spokesperson (e.g. case manager) to speak for you. If you know now that another person will represent you during your appeal, please complete the box below. You may file your request now and identify a representative to help you at a later time. | | | |
| I will *(PLEASE CHECK ONE)*: | **□ Represent** myself | | **□ Be** represented by someone else |
| **If you know now who your representative is, complete the section below:** | | | |
| *Name of Representative:* |  | | |
| *Relationship to You:* |  | | |
| *Address:* |  | | |
| *Telephone:* |  | | |

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| **[NAME OF PHP] complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. We do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.** |
| **[NAME OF PHP] will provide**:   * Free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, audio, accessible electronic formats, other formats). We will also provide extra assistance in asking for an appeal or seeing your file if you ask for it. * Free language services to people whose primary language is not English, including qualified interpreters and copies of notices and other important written information in your primary language. You may not be asked to provide your own interpreter (such as a friend or a family member) except in an emergency. |
| If you need any of these free services, contact [NAME OF DESIGNATED PHP STAFF PERSON AND PHONE NUMBER]. If you believe that [NAME OF PHP] has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can follow the grievance procedures found at: [INSERT INFO ON PHP GRIEVANCE PROCEDURE].  You can also file a grievance with the state Medicaid agency. Information can be found at: <https://www.ncdhhs.gov/about/department-initiatives/ada-grievance-procedure>  You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>  **or by mail or phone at:**  U.S. Department of Health and Human Services,  200 Independence Avenue SW., Room 509F, HHH Building,  Washington, DC 20201,  1–800–868–1019, 800–537–7697 (TDD)  **Complaint forms are available at:**  <http://www.hhs.gov/ocr/office/file/index.html> |

For language assistance with the enclosed document call the number listed below:

**ATENCIÓN:  si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística.  Llame al** **[APPROPRIATE NUMBER][APPROPRIATE TTY NUMBER].**

**注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].。**

**CHÚ Ý:  Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn.  Gọi số [APPROPRIATE NUMBER]** **[APPROPRIATE TTY NUMBER].**

**주의:  한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.  [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER]. 번으로 전화해 주십시오.**

**ATTENTION :  Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.  Appelez le [APPROPRIATE NUMBER][APPROPRIATE TTY NUMBER].**

**ملحوظة:  إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان.  اتصل برقم [APPROPRIATE NUMBER](رقم هاتف الصم والبكم: [APPROPRIATE TTY NUMBER].**

**LUS CEEV:  Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.    Hu rau 1-[APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**ВНИМАНИЕ:  Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода.  Звоните [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**PAUNAWA:  Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad.  Tumawag sa [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો  [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**ប្រយ័ត្ន៖  បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។  ចូរ ទូរស័ព្ទ [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].។**

**ACHTUNG:  Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung.  Rufnummer: [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**ध्यान दें:  यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].पर कॉल करें।**

**ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ [APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].**

**注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。[APPROPRIATE NUMBER] [APPROPRIATE TTY NUMBER].まで、お電話にてご連絡ください。**