**DECISION ON YOUR REQUEST FOR SERVICES**

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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 OR LEGAL GUARDIAN]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  [CITY, STATE, ZIP] | | | [REQUESTOR NAME]  [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 REQUEST], you or your provider asked us to approve your request for a healthcare service or item. | | | | | |
| Choose an item. | | | | | |
| **IF YOU DON’T AGREE WITH OUR DECISION, YOU CAN APPEAL IT.**  This letter tells you about our decision. Please read it carefully.  To ask for an Appeal, fill out and send us your Appeal Request Form. You will find it in this notice.  You can also call us to ask for an Appeal. The phone number is: [INSERT PHONE NUMBER].  The last day to ask for an Appeal is [INSERT 60TH DAY AFTER DATE OF NOTICE MAILED. IF THE 60TH DAY IS A SAT/SUN OR HOLIDAY, INSERT THE DATE FOR THE NEXT BUSINESS DAY]. You have 60 days from the date on this Notice to ask for an Appeal. | | | | | |

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| **YOU ASKED FOR:** | | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | | **Requested Dates** | **Requested Amount** |
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| **WE APPROVED:** | | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | | **Approved Amount** |
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|  |  |  |  |  | |  |
| **WE DENIED:** | | | | | | |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Denied Dates** | | **Denied Amount** |
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| **COMMENTS**:  [PHP DEFINED FREE TEXT AVAILABLE] | | | | | | |
| 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]. | | | | | | |
| 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]. | | | | | | |
| DD 3: **North Carolina Medicaid does not cover the following service(s) in our State Medicaid Plan:**  [CODE] [SERVICE DESCRIPTION]. | | | | | | |
| **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].** | | | | | | |

**IF YOU DON’T AGREE WITH OUR DECISION, YOU HAVE A RIGHT TO APPEAL IT**

**FOLLOW THESE INSTRUCTIONS TO ASK**[INSERT PHP NAME] **FOR AN APPEAL**

It is easy to ask your Plan for an Appeal. Follow the steps below:

* **Step One:** **Fill out and sign the Appeal Request Form that came with this Notice.**
* **Step Two: Fax or mail the Appeal Request Form to** [INSERT PHP NAME]**.**

Your Appeal Request Form is included with this Notice. Faxing your Form is the quickest way to get it to us. Use the fax number listed on your Form. You may also mail your Form, drop your Form off in-person or make a phone call to your Plan to ask for an Appeal. Use the phone number listed on your Form. **You must still send us your signed Form after you call.**

[INSERT PHP NAME] will send you a letter as soon as we get your Appeal Request Form. We must give you a decision on your Appeal within thirty (30) calendar days.

[INSERT PHP NAME]must receive your Appeal Request Form by [INSERT 60TH DAY AFTER DATE OF NOTICE MAILED- IF THE 60TH DAY IS A SAT/SUN/HOLIDAY, INSERT THE DATE FOR THE NEXT BUSINESS DAY]. The decision in this Notice becomes final on this date. If you are not able to send your Form by this date, call your Plan for more help.

**YOU WILL RECEIVE ANY SERVICES WE APPROVED IN THIS DECISION, EVEN IF YOU ASK FOR AN APPEAL**

You will receive any services we approved in the request you made on [INSERT DATE OF REQUEST]. You can always ask for more services while we finish your Appeal.

**REMEMBER TO SEND US YOUR APPEAL FORM WHEN YOU ASK FOR YOUR APPEAL BY PHONE**

You can also make a phone call to [INSERT PHP NAME] within 60 days to ask for an appeal. After you call, please fill out and send your Appeal Request Form right away. We need your signed Form for us to work on your appeal. We also need your signed Form when you name someone to help you with your Appeal. [INSERT PHP NAME] must receive your Form by [INSERT 60TH DAY AFTER DATE OF NOTICE MAILED- IF THE 60TH DAY IS A SAT/SUN/HOLIDAY, INSERT THE DATE FOR THE NEXT BUSINESS DAY].

**YOU MAY ASK SOMEONE TO HELP YOU WITH YOUR APPEAL**

You may ask someone to help you with your Appeal. Include their name and contact information on the Appeal Request Form. You may name someone to help you after you send your Form, but you must still give your permission in writing.

**YOUR REVIEWER WILL BE PROFESSIONAL, IMPARTIAL AND FAIR**

A healthcare professional will decide your Appeal. This person is licensed or is credentialed to provide care in your service specialty. Your reviewer didn’t make the decision found in this Notice. Also, your reviewer is not supervised by anyone who was involved in making this decision.

**IF YOU NEED MORE THAN 30 DAYS TO GATHER AND PRESENT YOUR INFORMATION**

[INSERT PHP NAME] must finish your appeal within 30 days of receiving your request. Sometimes, we need more time to make the best decision for you. A request for more time is called an extension. **We can only ask for more time if it will help us to approve your request.** If we need more time to finish your Appeal, we will inform you by mail. The letter will tell you what to do if you don’t agree with the extension. If you need more time to get new information to us, you may call [INSERT PHP HELPLINE] to ask for it.

**EXPEDITED APPEALS**

If you need a quick decision because your life, your physical or mental health, or your ability to regain function is in danger, you can ask your plan for an ‘expedited (faster) appeal’. If your provider asks us for an expedited appeal, or if we approve your request for a quick decision, we will finish your review no later than 72 hours after we get your Form. If we do not approve your request for an Expedited Appeal, we will finish our decision on your appeal within 30 days.

To ask for an expedited appeal call [INSERT PHONE NUMBER].

If we deny your request for an Expedited Appeal:

* We will give you a phone call during our business hours immediately following our decision;
* We will mail you a written notice within two calendar days;
* You may file a formal grievance with us if you don’t agree.

To file a grievance, call [INSERT PHP HELPLINE NUMBER].

**YOUR RIGHT TO ASK FOR A STATE FAIR HEARING (STATE APPEAL)**

You will receive a Notice of Decision from [INSERT PHP NAME] within 5 business days after the day we finish your Appeal. If you don’t agree with our decision, you can ask for a State Fair Hearing. You can ask for a State Fair Hearing without waiting any longer whenever:

* We take longer than 30 days to finish your Appeal without your permission, or;
* we do not send you a notice of that decision.

You will receive all instructions and forms you will need to request a State Fair Hearing in the same letter as your Appeal decision. You can also learn more about the North Carolina Medicaid Fair Hearing process at:

NC Medicaid ‘Your Due Process Rights’:

<https://medicaid.ncdhhs.gov/medicaid/your-rights>

North Carolina Office of Administrative Hearings:

**(919) 431-3000 1-866-219-5262 (toll-free)**

<http://www.ncoah.com/hearings/medicaid.html>

**DO YOU HAVE QUESTIONS OR NEED HELP?**

If you need help with your paperwork or have question, call us at: [INSERT PHP HELPLINE NUMBER].

**DO YOU NEED LEGAL HELP WITH YOUR APPEAL**?

To find the Legal Aid of NC Office nearest to you, call:

**1-866-219-5262 (toll-free)**

For persons with a disability, Disability Rights of North Carolina may be reached at:

**919-856-2195 or 1-877-235-4210 (toll-free)**

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| **Date:** [DATE OF LETTER] | | **Decision made by:** [PHP NAME] | |
| [MEMBER NAME] | | [ADDRESS LINE 1]  [ADDRESS LINE 2]  [CITY, STATE, ZIP] | |
| [LEGAL GUARDIAN IF APPLICABLE] | |
| [MEMBER MID] | |
| **DIRECTIONS:** To request an Appeal, complete this form and return it to [PHP] at the address or fax number below. You may return this form by fax, mail or by hand delivery. You can also telephone us at [INSERT PHONE NUMBER] to ask for an Appeal. You will still have to return this form after you call. The Appeal Request Form must be **received** by [PHP] by [60th DAY AFTER DATE OF NOTICE]**.** | | | |
| [PHP NAME]  Attention: [DEPARTMENT]  [ADDRESS LINE 1]  [ADDRESS LINE 2]  Telephone: [XXX-XXX-XXXX]  Fax: [XXX-XXX-XXXX] | | | |
| **This space intentionally blank** | | | |
| **I WOULD LIKE TO APPEAL THE [INSERT DATE] DECISION ON MY [SERVICE NAME] REQUEST.** | | | |
| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **□** Sign Language | | | |
| I will *(PLEASE CHECK ONE)*: | **□ Represent** myself | | **□ Be** represented by someone else |
| **If you know now who will be your representative, complete the section below:** | | | |
| *Name of Representative:* |  | | |
| *Relationship to You:* |  | | |
| *Address:* |  | | |
| *Telephone:* |  | | |

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Signature of Member or Legal Guardian Date Telephone Number

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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。**