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Insert Logo Here

If the letters are too small or the words are hard to read, call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for or what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and lay outs if you need it. If you are deaf or have difficulty hearing, you can call 7-1-1.

NOTICE OF ADVERSE BENEFIT DETERMINATION	
TO : _____	DATE : _____
FROM : _____	
<i>(You or your provider - as appropriate) have asked that (Health Plan Name) pay for (describe services requested and the reason for the services in easily understood language).</i>	
OUR DECISION	
<i>(Insert action being taken here and date effective if terminating or reducing a current service).</i>	
THE REASONS FOR OUR DECISION	
FACTS ABOUT YOUR CONDITION OR SITUATION THAT SUPPORT OUR DECISION	
<i>(Insert the reason for the adverse benefit determination, which must be complete and in common, easily understood language. The explanation must be both member and fact specific, describing the member’s condition and the reasons supporting the Contractor decision. If the reason for the denial is a lack of information, the missing info must be identified so the member has an opportunity to provide it)</i>	

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LEGAL BASIS FOR OUR DECISION

We based our decision on:
(Insert correct legal citation here)

You can ask for the guidelines or information we used to make this decision. Your doctor can also call us to talk about our decision.

Copies of Legal Citations can be found at the local library or Attachment B

YOUR RIGHTS IF YOU DISAGREE WITH THIS DECISION

If you are not happy with this decision, you can ask us to look at the decision again. This is called an appeal. You can appeal by telling us over the phone or in writing. To file an appeal, you must call us at *(Insert grievance phone number)* or write us at *(insert Contractors mailing address here)*. We must receive your appeal no later than *(insert date, 60 calendar days after the date of this Notice. If the 60th day falls on a weekend or holiday the Contractor must use the next business day)*. ~~Your provider, who requested authorization, has the option to request an informational discussion with the Contractor's Medical Director informational~~

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When you call or write to us about your appeal, tell us your name, member ID, and what you are appealing.

You can also see your case file, medical records, other notes, and records. You can see any information we used for your appeal. There is no cost for the information. This information will be given to you before we make our decision.

Before we make our decision, you can also give us any information you think is helpful. This can include written notes, files, or other important information. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing. After we review your appeal, we will send you our decision in writing within 30 days of the date we took your appeal.

IF YOU NEED A FASTER DECISION ON YOUR APPEAL

If you or your provider think your health or ability to function will be harmed by waiting 30 days for a decision, you or your provider can ask us for a fast review. This is called an expedited request. You can request this by calling us and asking for an expedited appeal. If we agree, we will decide your appeal no later than 72 hours after we receive your appeal. If we do not think a fast review is needed, we will write to you within two days. We will also try to call you. Then, we will decide on your appeal within 30 days.

GETTING HELP IF YOU WANT TO APPEAL THIS DECISION

You can have anyone you choose to help you appeal: your doctor, other health care provider, guardian/representative, attorney, or other representative can appeal for you. If you want someone to help, you will need to write to us giving them permission. If you would like legal help with this decision, you can contact the legal aid program in your county. There is a list of programs in Attachment B, Legal Services Program. You can also contact the State Protection and Advocacy System, the Arizona Center for Disability Law, at 1-800-927-2260. Persons determined to have a Serious Mental Illness (SMI) may also ask for help by contacting an Advocate at the AHCCCS Office of Human Rights at 1-800-421-2124 or 602-364-4585.

TAKING MORE TIME TO APPEAL

For all appeals, we can take up to 14 more days to make a decision. This is called an extension. If we want an extension, we will write to you and tell you why we need it and how it is helpful to you. If you want an extension, you can ask for it by writing or calling us. If an extension is given, a decision for your appeal will be made in 44 days for a standard appeal and in 72 hours plus 14 more days for a faster (expedited) appeal. You can ask for a State Fair Hearing if we do not make a decision to your appeal within the required time frame.

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CONTINUING SERVICES WHILE WE MAKE A DECISION ON YOUR APPEAL

(Insert: "This paragraph does not apply to you" if the member has not been receiving the requested service)

If the service you are appealing is being cut back or stopped, you can ask to continue the service while we make a decision. If you want the services to keep going, you will need to let us know when you appeal. Your services will only continue if you appeal by ***(insert date, 10 calendar days from the date of the Notice OR the intended date of the action or insert N/A if this paragraph does not apply)***. If you do not win your appeal, you might have to pay for the services you received during the appeal.

If you have questions about filing an appeal or need help, you can call us at ***(insert Contractor phone number here)***.

Sincerely,

(INSERT NAME OF DECISION-MAKING TEAM)