MODEL MLTC/MMC Approval Notice (Revised 7/25)
FOR SERVICE AUTHORIZATION, RECONSIDERATION, AND APPEAL DECISIONS
Template begins below this line

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR AGENT/Benefit Manager Name]
[Address]
[Phone]

APPROVAL NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee ID: [ID number or CIN]
Coverage type: [coverage type]
Service: [describe requested or claimed service including: amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [Plan reference number]

Dear [Enrollee]:

You are getting this notice because your health plan has [now] approved your [Service].

{*Insert for Requested Services*}[On [Date of Request] you asked [Plan Name] for the service listed above.]

{*Insert for Appeal Resolutions* } [On [Date of IAD], [Plan Name] [denied] [partially approved] [reduced] [suspended] [stopped] this [service]. You appealed that decision on [Date of Appeal Request]. [Insert summary of appeal.] On [Date of Appeal Resolution], the appeal was decided in your favor.

{*Insert for Approval on Reconsideration*}[On [Date of IAD], Plan Name] [denied] [partially approved] [reduced] [suspended] [stopped] this [service]. Your provider asked us to reconsider our decision on [Date of Reconsideration Request]. We decided to approve this service on [Date of Approval].]

[UR Agent Name] on behalf of] [Plan Name] has decided this service is [a covered benefit] [medically necessary] [approved to be provided by an out-of-network provider] [other determination].

[{*insert as for approval upon concurrent review, request for increase, or LTSS*}
[{insert as applicable}[Before this decision, from [STARTDATE] to [ENDDATE], this service was approved for:
[HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT.]]
{*insert as applicable*}[You or your provider requested approval for:
[HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc.]]

On [EFFDATE], the plan approved:
[HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc.]
This means from [NEWSTARTDATE] to [NEWENDDATE], your health care service is approved for:
[HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{Insert as applicable} [We will review your care again [IN TIME FRAME/ ON DATE.]]]

[{*insert for fully overturned decision upon appeal concurrent review, request for increase or LTSS*}
{*Insert as applicable*}[From [STARTDATE] to [ENDDATE], the plan approved:
[HOURS/DAYS, VISITS, LEVEL, QTY, etc., and PREVIOUS TOTAL AMOUNT]]
{*Insert as applicable*}[ON [Date] you or your provider requested approval for: [HOURS/DAYS, VISITS, LEVEL, QTY, etc.]]
On [DATEIAD] the plan approved: [HOURS/DAYS, VISITS, LEVEL, QTY, etc., and IAD TOTAL AMOUNT].
On [EFFDATE], the plan approved: [HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc.]
This means from [NEWSTARTDATE] to [NEWENDDATE], your health care service is approved for:
[HOURS/DAYS, HOURS/WEEK, VISITS, LEVEL, QTY, etc. AND NEW TOTAL AMOUNT]
{*Insert as applicable*}[We will review your care again [IN TIME FRAME/ ON DATE].]]]

[[Provider Name] is a [participating provider.] [an out of network provider.] You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.] *{or}* [This [service] will be provided by [a participating provider.] [an out of network provider.] You are not responsible for any extra payments, but you will still have to pay your regular co-pay or co-insurance if you have any.]]

{*Insert as applicable*}[insert plan disclosure statement regarding authorization subject to continued coverage, possible benefit limitations that may be reached prior to the enrollee receiving the authorized service, and/or payment is subject to the terms of the provider contract and plan policies and procedures.]

If you would like to speak to [Insert Plan Name] about this decision, please call [1-800-MCO PLAN]. {*Insert as applicable*}[To speak to {Insert UR Agent Name}, please call [1-800-UR AGENT].

You can file a complaint about your managed care at any time with the New York State Department of Health by calling [{for MMC}[1-800-206-8125] {or for MLTC}[1-866-712-7197].

Sincerely,

[MCO/UR AGENT/BENEFIT MANAGER Representative]

cc: Requesting Provider
{*Insert as applicable*}[At your request, a copy of this notice has been sent to:
[Enrollee Representative(s)]

ATTENTION: Language assistance services and other aids, free of charge, are available to you. Call <toll free number> <TTY/TDD>.	English
ATENCIÓN: Dispone de servicios de asistencia lingüística y otras ayudas, gratis. Llame al <toll free number> <TTY/TDD>.	Spanish
请注意：您可以免费获得语言协助服务和其他辅助服务。请致电 <toll free number> <TTY/TDD>。	Chinese
ملاحظة: خدمات المساعدة اللغوية والمساعدات الأخرى المجانية متاحة لك. اتصل بالرقم <toll free number> <TTY/TDD>.	Arabic
주의: 언어 지원 서비스 및 기타 지원을 무료로 이용하실 수 있습니다. <toll free number> <TTY/TDD> 번으로 연락해 주십시오.	Korean
ВНИМАНИЕ! Вам доступны бесплатные услуги переводчика и другие виды помощи. Звоните по номеру <toll free number> TTY/TDD>.	Russian
ATTENZIONE: Sono disponibili servizi di assistenza linguistica e altri ausili gratuiti. Chiamare il <toll free number> <TTY/TDD>.	Italian
ATTENTION : Des services d'assistance linguistique et d'autres ressources d'aide vous sont offerts gratuitement. Composez le <toll free number> <TTY/TDD>.	French
ATANSYON: Gen sèvis pou bay asistans nan lang ak lòt èd ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אכטונג: שפראך הילף סערוויסעס און אנדערע הילף, זענען אוועילעבל פאר אייך אומזיסט. רופט <toll free number> <TTY/TDD> .	Yiddish
UWAGA: Dostępne są bezpłatne usługi językowe oraz inne formy pomocy. Zadzwoń: <toll free number> <TTY/TDD>.	Polish
ATENSYON: Available ang mga serbisyong tulong sa wika at iba pang tulong nang libre. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
মনোযোগ নামূল্যে ভাষা সহায়তা পরিষেবা এবং অন্যান্য সাহায্য আপনার জন্য উপলব্ধ। <toll free number> <TTY/TDD>-এ ফোন করুন।	Bengali
VINI RE: Për ju disponohen shërbime asistence gjuhësore dhe ndihma të tjera falas. Telefononi <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Υπηρεσίες γλωσσικής βοήθειας και άλλα βοηθήματα είναι στη διάθεσή σας, δωρεάν. Καλέστε στο <toll free number> <TTY/TDD>.	Greek
توجہ فرمائیں: زبان میں معاونت کی خدمات اور دیگر معاونتیں آپ کے لیے بلا معاوضہ دستیاب ہیں۔ کال کریں <toll free number> <TTY/TDD>۔	Urdu