MODEL MLTC/MMC Approval Notice (Revised 11/24)
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, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
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 <toll free number> <TTY/TDD>.	Chinese
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم toll free number (رقم هاتف الصم والبكم) TTY/TDD >	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে৷ ফোন করুন ১-<toll free number> <TTY/TDD>	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں، تو آپ کو زبان کی مدد کی خدمات مفت میں دستیاب ہیں ۔ کال کریں <toll free number> <TTY:.	Urdu