

**Important:** This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

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[PLAN NAME/LOGO]

**Appeal Level: 1**

## NOTICE OF APPEAL DECISION DELAY

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**Name:**

**Date of Notice:**

**Enrollee Number:**

**Appeal Number:**

*[Insert other identifying information, as necessary (e.g., provider name, enrollee's Medicaid number, service subject to notice, date of service)]*

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Dear <Enrollee name> ,

On <date appeal received, orally or in writing> *[for expedited appeals insert: at <hour received>]* you, or someone acting for you, appealed the following action: *[Insert a brief description of the Plan action (e.g. denial, reduction, etc.) being appealed and the benefits involved.]*

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*[Insert the following section if the enrollee (or his/her representative) requested the extension:]*

### **You asked us to delay our appeal decision**

You, or someone representing you, asked for more time before <plan name> makes its decision on your appeal. We got your extension request on <date>. You asked for more time because: *[Give a brief description of the enrollee's request. Include the reason or purpose of the extension (e.g. submitting documentation for review, obtaining specialist review of enrollee medical condition, etc.), if known.]*

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Due to this request, we extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. If you no longer want the extension, call <plan name> immediately at: <phone number>. TTY users call <TTY number>.

*[Insert the following section if the plan initiated the extension:]*

## **We delayed our appeal decision**

We extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. We delayed the decision because: *[Explain why the decision was delayed. For example, the receipt of additional medical evidence from noncontract providers may be crucial to the appeal decision.]*

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This delay is in your interest and is allowed by federal regulation. If you think this delay is inappropriate, read "You can file a fast grievance" below for information about your rights.

*[Insert the following section if the plan needs additional information from the enrollee to decide the appeal:]*

## **What we need from you**

To help us decide your appeal, please submit the following information or materials: *[Request any items from the enrollee which may have prompted the delay, e.g. witness statements, non-network provider records, etc.]*

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We recommend keeping a copy of everything for your records. Send the information or materials by mail, fax, or phone to:

**<Plan name>**  
<Name of Appeals/Grievance Department>  
<Mailing Address for Appeals/Grievance Department>  
Phone: <phone number> TTY: <TTY number>  
Fax: <fax number>

## **You can file a fast grievance**

If you think we made a mistake by extending the appeal decision deadline, you or someone acting for you can file a fast grievance (also known as an "expedited" grievance). This will allow someone

else at <plan name> to decide whether the extension is appropriate. We will respond to your grievance within 24 hours. Follow these steps to file a fast grievance.

**Step 1** – Gather your information and materials. You will need the following:

- Your name
- Your date of birth (or other identifying information, like your enrollee number)
- Your contact information (for example: your phone or mailing address)
- Reason(s) why delaying the decision is not in your interest
- Any evidence or information that you want us to review to support why delaying a decision is not in your interest

*[If the plan requires any specific information to address the grievance, insert the following text:]*

Please submit the following specific information to help us reach a decision on your grievance:

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**Step 2** – Send the information and materials by mail, fax, or phone. You can also deliver it in person. We recommend keeping a copy of everything for your records.

**Grievance Contact Information:**

Phone .....<phone number>  
Regular Mail .....<address>  
Fax.....<fax number>  
Delivery in Person.....<address>  
Contacting your Care Manager .....<phone number>

**If you want someone to represent you**

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, or attorney.

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, before that person is able to act for you, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. Send your letter or form to us by fax or mail. Keep a copy for your records. If you have any questions about naming your representative, such as what to say in your letter, call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the MAP program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

*[Plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:]*

A copy of this notice has been sent to: <name>  
<address>  
<phone number>

## Get help & more information

(TTY users call 711, then use the phone numbers below)

- <Plan name>  
Website: <plan website>  
Toll Free Phone: <phone number>  
TTY users call: <TTY number>  
<days and hours of operation>
- Independent Consumer Advocacy Network (ICAN)  
633 Third Ave, 10th Floor  
New York, NY 10017  
Website: <http://icannys.org>  
Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  
Toll Free Phone: 1-844-614-8800  
8:00am – 6:00pm, Monday – Sunday
- 1-800-MEDICARE (1-800-633-4227)  
TTY users call: 1-877-486-2048  
24 hours a day, 7 days a week
- NYS Department of Health  
Bureau of Managed Long Term Care  
Toll Free Phone: 1-866-712-7197
- Medicare Rights Center  
Toll Free Phone: 1-888-HMO-9050
- Community Health Access to Addiction and Mental Healthcare Project (CHAMP)  
633 Third Ave, 10th Floor  
New York, NY 10017  
Web:  
<https://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ>  
Email: [ombuds@oasas.ny.gov](mailto:ombuds@oasas.ny.gov)  
Phone: 1-888-614-5400 (TTY Relay Service: 711)

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*[Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidance and any state-specific guidance provided by the New York State Department of Health.]*