

<Plan Name/Logo>

## COVERAGE DETERMINATION NOTICE

<Plan name> has *[Insert as applicable: denied or reduced or stopped or restricted]* your  
*[insert benefit type (list all if more than one)]*

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Name:

Date:

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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**Your services were *[Insert as applicable: denied or reduced or stopped or restricted or partially denied]* and you can appeal this decision.**

We *[Insert as applicable: denied or reduced or stopped or restricted or partially denied]* *[Insert if applicable: the payment of]* the services listed below: *[List the benefit changes or denial below. Indicate the services requested and the date of the request; for stoppages, reductions, or restrictions in benefits indicate (1) the benefit(s) affected and the level they were previously authorized, if applicable, and (2) the benefit(s) as currently authorized (or not).]*

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*[Insert in all cases except for post-service cases for which there is no member liability:*  
**This decision will take effect on: <effective date>.]**

*[Insert if this is a post-service case for which there is no member liability:*  
**you will not be billed or owe any money for this service.]**

Keep reading to learn what you can do if you disagree with the decision. You have the right to appeal this decision.

**Who *[Insert as applicable: denied or reduced or stopped or restricted or partially denied]* your services?**

Your services were *[Insert as applicable: denied or reduced or stopped or restricted]* by <plan name>. *[If the coverage decision was made by an authorized specialist, replace the plan name in the prior sentence with the name of the specialist.]*

**Why were your services *[Insert as applicable: denied or reduced or stopped or restricted or partially denied]*?**

The services listed above were [*Insert as applicable: denied or reduced or stopped or restricted or partially denied*] because: [*Provide specific rationale for the actions or decisions identified above. Include State or Federal law or coverage policy citations, where applicable, to support the decision. Include clinical rationale, if any, and indicate that the enrollee may request the relevant clinical review criteria.*]

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## **You can appeal this decision.**

You have the right to ask <plan name> to review this decision by asking for an appeal. <Plan name> will review your request and determine whether to give you the requested services. There are four levels of appeal. Asking <plan name> to review this decision is Level 1.

**How to appeal:** Ask <plan name> for an appeal within **65 calendar days** of the postmark date of this notice. If you appeal late, we may still be able to accept your appeal if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with <plan name>" for more information.

*[Insert the following paragraph when the service that is subject to this notice is stopped, restricted, or reduced:*

**How to keep your services while the appeal is processing:** If we are stopping, restricting, or reducing services that were previously approved, you can keep getting those services while your case is being reviewed. To qualify, ask <plan name> for an appeal within **10 calendar days** of the postmark date on this notice or by the effective date of this decision (<effective date>), whichever is later. You will always have 65 calendar days to file your appeal. However, if you want to keep getting those services while your case is being reviewed, you must, you must meet the 10-day deadline. If you do, your disputed services will stay as they are now while your appeal is pending.]

## **Anybody can request an appeal for you.**

You can have someone else file your appeal or represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, or attorney. 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 enclosed Appointment of Representative form [*Plans must enclose an Appointment of Representation Form when sending this notice.*] 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, call us at: <phone number>. TTY users call <TTY number>.

<Plan Name>

<Name of Relevant Department>

<Mailing Address>

Fax: <Fax>

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. You can also reach them by email at [ican@cssny.org](mailto:ican@cssny.org), or go to their website at [www.icannys.org](http://www.icannys.org)

## When will we decide your appeal?

**Standard Appeal** – We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal (or 7 calendar days for Medicare Part B prescription drug appeals).

**Fast Appeal** – You have the right to request a Fast Appeal. We will give you a decision on a Fast Appeal within 72 hours after we get your appeal.

- You can ask for a Fast Appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision (or 7 calendar days for Medicare Part B prescription drug appeals).
- **We will automatically give you a Fast Appeal if a doctor asks for one, if your doctor supports your request in writing, or you are asking for more of a service you are getting now.** If you ask for a Fast Appeal without support from a doctor, we will decide if your request requires a Fast Appeal. If we do not give you a Fast Appeal, we will tell you, and we will treat your case as a Standard Appeal and give you a decision within 30 calendar days (or 7 calendar days for Medicare Part B prescription drug appeals).

**For both Standard and Fast Appeals, we can take up to 14 calendar days longer to decide** if you ask for an extension, or if delaying the decision is best for you. If we take this extra time to decide, we will send you a written notice to explain why. We can't take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

## How to ask for an appeal with <plan name>:

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

- Your name
- Address
- Enrollee number
- Reason(s) for appealing
- Whether you want a Standard or Fast Appeal (For a Fast Appeal, explain why you need one. It is very helpful to have a doctor submit a statement in support of your Fast Appeal.)
- Any evidence or information that you want us to review to support your case, such as medical records, doctors' letters (such as a doctor's supporting statement if you request a Fast Appeal), or other information that explains why you need the item or service. Call your doctor if you need this information.



We will send you a free copy of the medical records and any other information we will use to make the appeal decision. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

If you would like us to consider any evidence or testimony before we make our decision, you should submit it **as soon as possible**. You can submit evidence or testimony **1)** over the phone, **2)** by mail or fax, or **3)** by hand delivery at our drop-off location before your review. We recommend keeping a copy of everything for your records. Please submit evidence or testimony to:

**<Plan name>**  
<Name of Appeals/Grievance Department>  
<Mailing Address for Appeals/Grievance Department>  
<Drop-off Address, if applicable>  
Phone: <phone number> TTY: <TTY number>  
Fax: <fax number>

### **Do I have other appeal rights?**

You have other appeal rights if your plan said a **Medicaid service** was:

1. Not medically necessary,
2. Experimental or investigational,
3. Not different from care you can get in the plan's network, or
4. Available from a participating provider who has correct training and experience to meet your needs.

For these types of decisions, you may also be eligible for an External Appeal. An External Appeal is a review of your case by health professionals that do not work for your plan or the State. You may need your doctor's help to fill out the External Appeal application.

Before you ask for an External Appeal:

- You must file a Plan Appeal and get our decision on your appeal; or
- If we (your health plan) agree, you may also ask for a Fast Track External Appeal at the same time that you ask for a Fast Appeal; or
- If we (your health plan) agree you can skip the plan appeal process and go directly to the External Appeal.

You have 4 months to ask for an External Appeal from when you receive our decision on your appeal, or from when we agree to skip the plan appeal process.

To get an External Appeal application and instructions:

- Call <plan name> at <PLAN'S TOLL FREE #>; or
- Call the New York State Department of Financial Services at 1-800-400-8882; or
- Go on line: [www.dfs.ny.gov](http://www.dfs.ny.gov)

The External Appeal decision will be made in 30 days. Fast track decisions are made in 72 hours. The decision will be sent to you in writing. If you ask for an External Appeal and we automatically forward your case to the Office of Administrative Hearings (OAH), the decision of the fair hearing officer will be the one that counts.

## 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.]*

<Plan name>  
**APPEAL REQUEST FORM**

**Mail this form to:** <Address>  
<City, State Zip>

**Fax to:** <Fax number>  
**Email to:** <Email address>

**Enrollee Information** [*the plan should auto-populate the enrollees Information*]

Name: <First Name> <MI> <Last Name>  
Enrollee ID: <Enrollee ID>  
Address: <Address> <City, State Zip>  
Home Phone: <Home Phone> Cell Phone: <Cell Phone>  
Date of Birth: <DOB>

**Requester (if different from above)**

Name: \_\_\_\_\_ E-mail: \_\_\_\_\_

Address: \_\_\_\_\_ Fax #: (\_\_\_\_) \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_

Does the Requester intend to represent the Enrollee  YES  NO

**Appeal Information**

Today's date: \_\_\_\_\_ Service you are appealing: \_\_\_\_\_

Reason for requesting appeal: \_\_\_\_\_

I request an In-Person Review. If checked, is member homebound?  YES  NO

Is an Interpreter needed?  YES  NO Language: \_\_\_\_\_

I need an accommodation for my disability for this appeal. The accommodation(s) I need are: \_\_\_\_\_

I enclosed additional documents for consideration for the appeal.

I request a FAST APPEAL because my health could be seriously harmed if the decision takes 30 days.

I request the clinical guidelines and/or other rules or regulations used to make my determination.  
Please send these documents to:

Me  My representative (see above)