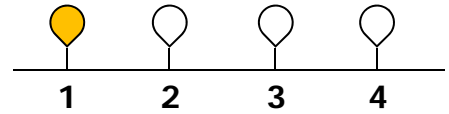


Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]

Appeal Level: 1



ACKNOWLEDGMENT OF APPEAL

Name:

Date of Notice:

Participant Number:

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

Dear <Participant 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 FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved.]*

[Insert if 1) the action involves a stoppage, reduction, or restriction on a previously authorized benefit, and 2) the appeal was received within 10 days of the ICDN postmark date or the date the action was intended to take effect, whichever is later: You will continue to get the disputed service while your appeal is processing.]

<Plan name> contact information

You can contact <plan name> with questions about your appeal or this notice using the following contact information:

<Plan name>

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

Appeal review process

This is Level 1 of the appeal process. <Plan name> is reviewing the appeal requested for the action described above. No persons assigned to review your appeal were involved in the original action. We will mail a notice to you and your representative (if you have one) when we make a decision. The notice will explain our decision and what you can do if you disagree.

We will make a decision about your appeal by [*Insert date/time of appeal decision deadline (72 hours from receipt of appeal for fast appeals, 7 calendar days from receipt of appeal for standard Medicaid prescription drug appeals, 60 calendar days from receipt of appeal for reimbursement requests, and 30 calendar days from receipt of appeal for all other standard appeals)*]. [*Insert for expedited appeals: We will try to contact you in person or by phone as soon as we decide your appeal.*]

If you would like extra time to submit information to support your appeal, you can ask us to delay our decision by up to 14 more calendar days. Or, if we need to gather more information to decide your appeal, we can take up to 14 more calendar days to make our decision. If we take extra time, we will notify you in writing. If you believe we should not take more time to make a decision, you can file a fast grievance. We will respond to your grievance in 24 hours.

[*Insert the following section if plan denied request for a fast appeal:*]

Denial of fast appeal

We denied your request for a fast appeal. If you think we made a mistake, you can file a fast grievance. For more information, please see the enclosed notice titled "We Cannot Give You a Fast (or "Expedited") Appeal."

Request an in-person or phone-based review

Our review of your appeal will occur at our office by staff who were not involved in the original decision. These individuals will review the documents we have and any that you submitted or that were submitted for you, and they will make a decision on your appeal. This is called a desk review.

You are, however, entitled to a reasonable opportunity to present your case in-person or by phone if you do not want a desk review. If an in-person or phone-based review is requested, we will arrange a time (and location) with you or your representative (if you have one) and send a notice by mail to confirm.

Transportation to in-person review

If you have requested an in-person review, you, and any witnesses that may require it, are entitled to receive necessary transportation to and from the in-person review. If you are homebound, or if transportation could be harmful to your health or safety, make sure to request that the in-person review is conducted at your home or other residence.

<Plan name> will only provide transportation or an at-home review when necessary. It is important for you or your representative to give <plan name> an explanation for why transportation services or an at-home review is needed.

Getting your case file and submitting evidence

You have the right to get a copy of any documents from your case file with <plan name> that will help you show why our decision was wrong. You or your representative (if you have one) may request these documents, at no cost, by calling <phone number> or by fax to <fax number>.

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 may also present evidence or testimony at an in-person or phone-based review, if requested. You can submit evidence or testimony **1)** over the phone, **2)** by mail or fax, **[or] 3)** at your in-person review [*Insert if the plan has a drop-off location: , or 4)* by **hand delivery at our drop-off location before your review**]. 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>

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, attorney, or an ICAN staff member (see below).

If you already named someone to represent you when you requested 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, 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 <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>. Send your letter or form to us by fax or mail, or give it to your Care Manager. 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 FIDA 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, and may even represent you. 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>
Toll Free Phone: <phone number>
<hours of operation>
- Independent Consumer Advocacy Network (ICAN)
<http://icannys.org>
Email: ICAN@cssny.org
Toll Free Phone: 1-844-614-8800
8:00am – 8:00pm, Monday – Sunday
- Health Insurance Information, Counseling and Assistance Program (HIICAP)
Toll Free Phone: 1-800-701-0501
- 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

<Plan's legal or marketing name> is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. *[This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

You can also ask for this information in other formats, such as Braille or large print.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.