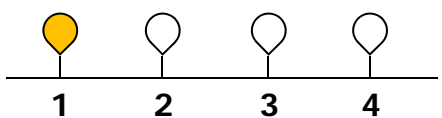


**Important:** This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]

**Appeal Level: 1**



1 2 3 4

## APPEAL DECISION NOTICE

**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>,

<Plan name> reviewed your appeal, received on <date appeal received, orally or in writing> *[for expedited appeals insert: at <hour received>]*, about the following action: *[Insert a detailed description of the FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved (provide more detail than the Appeal Acknowledgement letter). Also, include the original rationale for the FIDA Plan action/IDT decision that is the basis of the Participant's appeal.]*

### Level 1 Appeal decision

Your appeal was *[Insert if applicable: partially]* denied on <date of appeal decision>. That means we upheld *[Insert if applicable: part of]* the previous decision made on <date of plan coverage determination or PCSP update, as applicable>. We *[Insert if applicable: partially]* denied your appeal because: *[Insert specific rationale for the appeal decision, addressing each initial decision and rationale listed above. Include citations or clear references to State or Federal coverage rules and guidelines, FIDA Program coverage rules, or other clinical guidelines that were used to support the appeal decision. Describe the clinical rationale, if any, and indicate that the Participant, or his/her representative, if applicable, may request the relevant clinical review criteria at no cost to them.]*

*[Insert the following three paragraphs for decisions that are partially favorable to the Participant:]*  
However, we decided to approve the following services: *[List the services that were approved, including any applicable information about coverage amount, duration, etc.]*

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You are authorized to receive these services as of <date authorized (no later than one business day after the FIDA Plan appeal decision date)>. If you do not receive the services, or if the services are wrongly stopped or reduced, tell us immediately using the contact information below:

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

You can also contact the **Independent Consumer Advocacy Network (ICAN)** to help you resolve the issue. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

## What this means

Because our Level 1 Appeal decision is not fully in your favor, the appeal process automatically continues. You will now begin Level 2 of the appeal process, and we are forwarding your case to the **FIDA Integrated Administrative Hearings Office (IAHO)**. The IAHO is an independent organization that is not connected to <plan name>.

You will receive a second notice to confirm that your case was forwarded to the IAHO. Someone from the IAHO will contact you to schedule a hearing regarding the following disputed services: *[List all services that are still fully or partially disputed after the Level 1 decision.]*

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The IAHO will conduct the hearing and make a decision as soon as your condition requires. You have the right to do your hearing over the phone or in-person. If you need reasonable accommodations because of a disability, tell the IAHO and they will provide those accommodations for you. If you are homebound, or if transportation could be harmful to your health, make sure to request that the hearing is conducted at your home or other residence.

## Continuation of services during your Level 2 Appeal

*[Insert the following two paragraphs if any of the disputed services are continued:]*

Because you had continuing services during Level 1 of your appeal, the following disputed services will also continue pending the outcome of Level 2: *[List the disputed services that qualify for continuation of benefits.]*

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If these services are stopped before the IAHO makes a decision, contact us at <phone number> or the **Independent Consumer Advocacy Network (ICAN)** at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800. If the IAHO upholds our decision, you will not have to pay for any continued services.

*[Insert the following paragraph if none of the disputed services qualify for continued benefits:]*  
You will not receive the disputed services at this time. <Plan name> will not take any action regarding these benefits until your appeal is resolved by the IAHO, or until we come to an agreement about the disputed services.

*[Insert the following paragraph if the Participant did not qualify for continuation of services, but the plan partially (but not fully) approved any of the disputed benefits from the original FIDA Plan action/IDT decision:]*

You requested *[insert benefit and amount requested]*. <Plan name> approved *[insert benefit and amount approved]*. You are appealing this approval because it is not what you requested. We will provide you with the approved services while your appeal goes to Level 2 of the appeal process to decide whether we have to provide you with what you requested.

## 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 the IAHO to consider information that was not considered by <plan name>, you should submit it **as soon as possible**. We recommend that you submit the information by phone, fax, or email. You may also submit it by mail, bring it to the IAHO office, or present it at an in-person hearing:

### **FIDA Integrated Administrative Hearings Office (IAHO)**

Mailing Address: FIDA/IAHO-10A, P.O. Box 1930, Albany, NY 12201  
Physical Address: 317 Lenox Avenue, 7th Floor, New York, NY 10027

Phone: 1-844-523-8777

TTY Phone: Call 711, then follow the prompts to dial 844-523-8777

Fax: 518-474-8742

Email: [otda.sm.FIDA.Integrated.Appeals.Office@otda.ny.gov](mailto:otda.sm.FIDA.Integrated.Appeals.Office@otda.ny.gov)

## 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 IAHO by fax or mail. If you have any questions about naming your representative, such as what to say in your letter, contact IAHO using the information above or 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>
- 1-800-MEDICARE (1-800-633-4227)  
TTY users call: 1-877-486-2048  
24 hours a day, 7 days a week
- Independent Consumer Advocacy Network (ICAN)  
<http://icannys.org>  
Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  
Toll Free Phone: 1-844-614-8800  
8:00am – 8:00pm, Monday – Sunday
- NYS Department of Health  
Bureau of Managed Long Term Care  
Toll Free Phone: 1-866-712-7197
- Health Insurance Information, Counseling and Assistance Program (HIICAP)  
Toll Free Phone: 1-800-701-0501
- Medicare Rights Center  
Toll Free Phone: 1-888-HMO-9050

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<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](http://icannys.org).