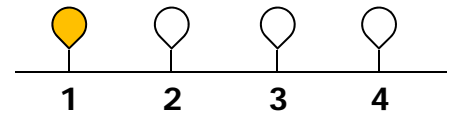


Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]

Appeal Level: 1



IN-PERSON APPEAL REVIEW

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 for in-person review requests made with the appeal: In your appeal you also requested an in-person review.] [Insert if the request is made after the appeal is filed: On <date of in-person review request>, you requested an in-person review.] We are sending this notice to let you know that your in-person review has been scheduled for:

Date: <date (chosen after contact with Participant to discuss availability)>

Time: <time>

Location: <address>

If you need to reschedule, call <phone number>.

Transportation to the in-person review

[Insert following paragraph if transportation was requested:]

You requested transportation to your in-person review. Your transportation request was *[insert as applicable: granted or denied]*. Call <phone number> for more information.

[Insert following two paragraphs if transportation was not requested:]

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 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 are needed. You can request transportation services by calling us at: <phone number>. TTY users call <TTY number>.

Filing a grievance

If you have been unable to schedule the in-person review at a time or location (such as your home) that works for you, you may file a grievance. If we denied your transportation request, you may file a grievance. To file a grievance, follow these steps:

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

- Your name
- Address
- Participant number
- Reason(s) why you need to reschedule the review, need transportation to the review, or need an in-home review
- Any evidence or information that you want us to review to support your case, such as medical records, doctors’ letters, or other information that explains why you need to reschedule, need transportation, or need an in-home review. Call your doctor or Care Manager if you need this information.

[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 our decision on your grievance:

Step 2 – Send the information and materials by mail, fax, or phone. You can also deliver it in person, or give it to your Care Manager.

Grievance Contact Information:

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

The in-person review process

[Insert an explanation of the procedures for the plan's in-person review. CMS and NYSDOH do not prescribe exact procedures, but you must at least tell the Participant that:

- He or she will be given an opportunity to argue their case on law and fact, submit evidence for review by the plan, and present witness testimony (either their own, or that of another—which may or may not be in-person), and*
- That no person(s) involved with the in-person review was involved in the original plan action/IDT decision.]*

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.

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 information before we make our decision, you should submit it **as soon as possible**. You do not have to wait until the in-person review, although we will accept it then as well. 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 haven't 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 written 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.