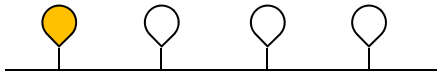
Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]

Appeal Level: 1



[*If information is needed from a provider, the plan should contact the provider to obtain the needed information. The plan may not put the onus on the Participant to obtain information that the plan may independently obtain.*]

REQUEST FOR ADDITIONAL INFORMATION

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.*]

We need more information to decide your appeal

To make the best decision possible, we need more information. Before <date that the information is needed by> please send us: [*Identify the information being requested.*]

We need this information because: [*Explain why the additional information is needed and what effect submitting it (or failing to submit it) might have.*]

You may be able to get the information from [*identify potential holders of the information; however, plans are responsible for seeking information from network and other known providers and, thus, these individuals should not be listed here*]. Let us know if you need help getting this information.

Where to send this information

To submit the information, or if you have any questions about our request, please use 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>

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.