

[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 <Non-Participating Provider 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 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.

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 by phone if you do not want a desk review. If a phone-based review is requested, we will arrange a time with you or your representative (if you have one) and send a notice by mail to confirm.

Submitting evidence

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 a 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.

If you already named someone to represent you when you requested this appeal, 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 and send it to us by fax or mail.

[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>