

[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.]

NON-PARTICIPATING PROVIDER 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 <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.]*

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.

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. Send your letter or form 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>