TEMPLATE G(12)

EXPEDITED COMPLAINT DECISION NOTICE

[Date Notice Mailed (no more than 2 days after the date of the decision)]

Participant Name
Address
City, State Zip

Participants ID: *********

Subject: Decision About Your Expedited Complaint

Dear **[Participant Name]**:

[CHC-MCO Name] has reviewed your Complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the Complaint review committee has decided that **[state decision in detail at a 6th grade reading level]**.

The reasons for this decision are: **[Explain at a 6th grade reading level in detail every reason for the decision. In addition to the explanation for the decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

[CHC-MCO: Include the following paragraph only if the Complaint challenges a denial because the service or item is not a covered service.]

To Continue Getting Services

If you have been getting services or items that are being reduced, changed, or denied and you ask for an external review or a Fair Hearing the services or items will continue until a decision is made. You must ask for an external review (see instructions below) verbally or in a letter that is hand-delivered, post marked, or faxed **within 10 days from the date on this notice**. Your request for a Fair Hearing (see instructions below) must be hand-delivered or postmarked **within 10 days from the date on this notice**. If you ask for both an external review and a Fair Hearing, you must ask for both the external review and the Fair Hearing **within 10 days from the date on this notice**. If you wait to ask for a Fair Hearing until after you receive a decision on your external Complaint, services will not continue.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

Ask for an Expedited External Review

You may ask for an "expedited external review" of the Complaint decision from the Pennsylvania Insurance Department **within 2 business days from the date you get this notice.**

To ask for an expedited external review of your Complaint:

- By Phone: Call **[CHC-MCO Name]** at **[Phone # & Toll-free TTY/PA RELAY #]**;
- By Fax: Fax a letter to **[CHC-MCO Name]** at **[CHC-MCO Fax #]**;
- By Mail: Send a letter to **[CHC-MCO Name]** at the following address:

[**CHC-MCO Address for requesting expedited external review]**

[**CHC-MCO: Include information on Fair Hearings only if the Complaint is about the following: a denial because the service or item is not a Covered Service or the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department.]**

Ask for a Fair Hearing

You may also ask for a Fair Hearing from the Department of Human Services.

To ask for an early decision

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly. For a decision to be made more quickly:

You can ask for an early decision by calling the Department at 1-800-757-5042 or by faxing a letter or the "Fair Hearing Request Form" to 717-346-7142.

Your doctor or dentist must fax a signed letter to 717-346-7142 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Even if you no longer need an early decision, you may ask for a Fair Hearing in writing and postmarked **within 120 days from the date on this notice.** You can either fill out and sign the "Fair Hearing Request Form" or write a letter.

If you write a letter, it needs to include the following information:

- Your (the Participant's) name, social security number/case record number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of this notice.
- A copy of the original denial notice, if available**. [CHC-MCO: Include this last item only for Complaints challenging a denial because a service or item is not a covered service or because the service or item was provided without authorization by a non-MA provider.]**

Send your request for a Fair Hearing to the following address:

Department of Human Services
OLTL/Forum Place 6th FL
CHC Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, PA 17105-8025

The Department will make a decision within 90 days from when you filed your Complaint with **[CHC-MCO Name]**, not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

Ask for Information Used to Make this Decision

You or your representative may ask **[CHC-MCO Name]** to see any information **[CHC-MCO Name]** used to decide your Complaint, at no cost to you.

To ask for the information used to decide your Complaint:

- Call **[CHC-MCO Name]** at **[CHC-MCO Phone # &Toll Free TTY/PA RELAY]** or
- Mail or fax a letter requesting the information to the following:

Fax number: **[CHC-MCO FAX #]**

Mailing address:
[ADDRESS FOR REQUESTING INFORMATION USED TO MAKE A DECISION]

Help with Your Request for Expedited External Review or Fair Hearing

If you need help asking for an external review or for a Fair Hearing, you can call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**.

To ask for free legal help with an external review or Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[CHC-MCO Name]

cc:
[Participant Representative, if designated]
[Service Provider, if applicable]
[Prescribing Provider, if applicable]

FAIR HEARING REQUEST FORM

(Please include a copy of the notice from **[CHC-MCO Name]** with this form)

Participant: _____ **Participant ID #:** _____

Phone number: _____

Address: _____

Date on the Complaint Notice: _____

Managed Care Plan:_____

1. **Check how you would like to be present at the Fair Hearing:**

   ☐ **BY TELEPHONE** (You will be sent the date and time of the Fair Hearing. You will be called at the phone number you provided above.)

   ☐ **IN PERSON** (You will be sent the date, time, and location of the Fair Hearing.)

2. **Will waiting the usual time frame for a Fair Hearing decision harm your health? Yes ☐ No ☐**

   (See instructions in the Complaint notice of decision about how to ask for an early decision.)

3. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____

   Interpreter and language services will be provided free of charge.

4. **Why do you disagree with [CHC-MCO Name's] decision?** (Attach more pages if needed. You will be able to fully explain your position during the Fair Hearing.)

   _____

   _____

   _____

_____

_____

_____

5. **If someone will be helping you with your Fair Hearing, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let the Department of Human Services know later if someone is helping you.)

   Representative's name and phone number: _____

   Representative's address: _____

   Relation to Participant: _____

Participant's Signature: _____ **Date:** _____

Send to: Department of Human Services
OLTL/Forum Place 6th FL
CHC Complaint, Grievance and Fair Hearings
P.O. Box 8025
Harrisburg, PA 17105-8025

or Fax : 717-346-7142 (only if asking for an early decision)

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]