TEMPLATE G(15)

EXPEDITED GRIEVANCE DECISION NOTICE

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

Participant Name
Address
City, State Zip

Participant ID: *********

Subject: Decision About Your Expedited Grievance

Dear **[Participant Name]**:

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

Based on a review of all information provided, the 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 denial. In addition to explanation for 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.]**

To continue getting services
If you have been getting the services or items that are being reduced, changed or denied and you ask for an external review (see instructions below) verbally or in a letter that is hand-delivered or postmarked **within 10 days from the date on this notice**, the services or items will continue until a decision is made or if you ask for a Fair Hearing (see instructions below) and your request is hand-delivered or postmarked **within 10 days from the date on this notice**, the services or items will continue until a decision is made.

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 Grievance decision from the Pennsylvania Department of Health **within 2 business days from the date you get this notice.** An external review is a review by a licensed doctor who does not work for **[CHC-MCO Name].**

To ask for an expedited external review of your Grievance:

- By Phone: Call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #];**
- By Email: Send an email to **[CHC-MCO]** at **[CHC-MCO email address]**
- 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 Name] will send your request to the Department of Health, which will send you more information about the expedited external review process.

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, or a copy of this notice; and
- A copy of the original denial notice, if available**.**

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 Grievance 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 Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- 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 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 your 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 the **[CHC-MCO Name]** with this form)

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

Phone number: _____

Address: _____

Date on the Grievance Notice of Decision: _____

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 Grievance notice of decision about how to ask for an early decision.)
3. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____
   The interpreter will be free.
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]