TEMPLATE G(9)

COMPLAINT DECISION NOTICE

[**CHC-MCO: Use if the Complaint is about the following: a denial because the service or item is not a Covered Service; the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department; the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the Medical Assistance Program; a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.]**

[Date Notice Mailed (date of the Complaint decision)]

Participant Name
Address
City, State Zip

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

Subject: Decision About Your 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]**.

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.]**

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

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 or a Fair Hearing (see instructions below) 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.

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

Ask for an External Review

You may ask for an "external review" of the Complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **within 15 days from the date you get this notice.**

To ask for an external review of your Complaint, send your request to one of the following addresses:

Pennsylvania Department of Health
Bureau of Managed Care
Health and Welfare Building, Room 912
625 Forster Street
Harrisburg, Pennsylvania 17120-0701
Telephone: 1-888-466-2787
Fax: 1-717-705-0947
Relay: 1-800-654-5984 (for persons with hearing impairments)

Pennsylvania Insurance Department
Bureau of Consumer Services
Room1209, Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone: 1-877-881-6388

Your request for external review by either Department must include the following information:

- Your (the Participant's) name, address, and day time telephone number;
- Your (the Participant's) **[CHC-MCO Name]** identification number;
- **[CHC-MCO Name]**'s name
- A brief description of the issue;
- A copy of this notice.

If you send your request for external review to the wrong Department, that Department will send it to the other Department.

Ask for a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be 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, Participant ID 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; and
- The reason(s) you are asking for a Fair Hearing, or 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.

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.

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 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 Complaint 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 Complaint 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]