TEMPLATE GG(1)

NOTICE FOR FAILURE OF PH-MCO TO MEET COMPLAINT OR GRIEVANCE TIME FRAMES

[Date Notice Mailed (1 day after the date the decision was to be made)]
Member Name
Address
City, State Zip
Member ID: *********

Subject: Your **[Complaint] [Grievance]** About **[Issue]**

Dear **[Member Name]**:

[PH-MCO Name] has not told you its decision on your **[Complaint] [Grievance]** about **[identify subject of Complaint/Grievance]**, filed on **[date]**, within **[number that is 30 or fewer days]**, as required. We expect to be able to tell you our decision about your **[Complaint] [Grievance]** by **[date]**.

If you are unhappy that **[PH-MCO Name]** has not told you about its decision on your **[Complaint] [Grievance]** within **[#]** days of getting it, you may file a Complaint with **[PH-MCO]** or ask for a Fair Hearing from the Department of Human Services.

File a Complaint

If you want to file a Complaint with **[PH-MCO Name]** about the delay in deciding your **[Complaint] [Grievance]**, you must file the Complaint **within 60 days from the date you get this notice.**

[PH-MCO Name] will tell you its decision about this new Complaint within **[30, unless the PH-MCO will be using a shorter time frame to provide notice of 1st level Complaint decisions]** days from when **[PH-MCO Name]** gets your Complaint.

To file a Complaint:

By Phone: Call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #];**

By Fax: Fax the “Complaint/Grievance Request Form” or a letter to **[PH-MCO FAX #];**

By Mail: Mail the “Complaint/Grievance Request Form” or a letter to the following address:

[PH-MCO ADDRESS
FOR FILING COMPLAINT]

Ask for a Fair Hearing

If you want to ask for a Fair Hearing from the Department of Human Services about the delay in deciding your **[Complaint] [Grievance],** 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 Member's) name 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
- A copy of this notice.

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

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Fax: 1-717-772-6328

The Department will make a decision within 90 days from when you filed your **[Complaint] [Grievance]** with **[PH-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.

Help with Your Complaint or Fair Hearing

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

To ask for free legal help with filing a Complaint or asking for a 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,

[PH-MCO Name]

cc: **[Member Representative, if designated]**

COMPLAINT/GRIEVANCE REQUEST FORM

Member: ____ **Member ID:** ______________________

Parent/Guardian: ____**Phone number:** ______________

Address: ____

Date on the Notice of Decision: ___________________________

1. **Check how you would like to be present at the review of your Complaint/Grievance:**
   ☐ **BY TELEPHONE** (You will be sent the date and time of the review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [PH-MCO to include only if available]** (You will be sent the date, time and location of the review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the Complaint. The decision on your Complaint or Grievance will not be affected if you are not present.)

2. **Would you like a copy of the information [PH-MCO Name] used to make the decision you are filing a Complaint/Grievance about? Yes ☐ No ☐**
3. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**__________
   (Interpreter and language services will be provided free of charge)
4. **Why do you disagree with [PH-MCO Name]'s decision?** (Attach more pages if needed. You will be able to explain why you disagree during the review.)
   ____
   ____
   ____
   ____

5. **If someone will be helping you with your Complaint, please provide his or her information:**
   (If you do not yet have anyone helping you, just leave this blank and you can let **[PH-MCO Name]** know later if someone will be helping you.)
   Representative's name and phone number: ___________________________________
   Representative's address: ____
   Relation to Member: ____

Member's Signature: ____**Date:**___________________

Send to: **[PH-MCO Complaint address and PH-MCO Complaint fax #]**

FAIR HEARING REQUEST FORM

(Please send in a copy of the notice you are requesting a Fair Hearing about, along with this form)

Member: ______________________________________ **Member ID:** _______________________

Parent/Guardian: ________________________________ **Phone number:** ___________________

Address: ____

Date on the Notice of Decision: ________________________________

1. **Check how you would like to be present your Fair Hearing**

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

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

2. **Will waiting the normal time frames harm your health? Yes ☐ No ☐**
   (See the instructions on your notice on how to ask for an early decision.)
3. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**__________
   (Interpreter and language services will be provided free of charge)
4. **Tell us why you disagree with our decision:** (Attach more pages if needed.)
   ____
   ____
   ____
   ____
   ____
   ____

5. **If someone will be helping you with your Fair Hearing, please provide their information:**
   (If you don't yet have anyone helping you, just leave this blank and you can let The Department of Human Services know later.)
   Representative Name and phone number: ____

   Relation to Member: ____

Signature: ____**Date:**__________________

Send to: Department of Human Services
OMAP- HealthChoices Program
Grievance, Appeal, and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Or Fax: 1-717-772-6328

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]