TEMPLATE GG(11)

SECOND LEVEL COMPLAINT DECISION NOTICE

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

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Second Level Complaint

Dear **[Member Name]**:

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

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

The reasons for this decision are: **[Explain in detail, at a 6th grade level, every reason for decision. In addition to explanation for decision, paraphrase references to approved criteria, rules, and/or protocols on which the decision is based. *If under the age of 21, denial must be based on medical necessity. If a member under the age of 21 is denied because of insufficient information to determine medical necessity, it must be clear that a medical necessity determination could not be reached with the available information and all information needed to render a decision must be listed. If denied because of insufficient information and 21 or older, identify all additional information needed to render decision.*]**

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY ASK FOR AN EXTERNAL REVIEW OF THE SECOND LEVEL 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 Insurance Department
Bureau of Customer Service
Room 1209 Strawberry Square
Harrisburg, PA 17120
Telephone: 1-877-881-6388

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
AT&T Relay: 1-800-654-5984 (for persons with hearing impairments)

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

- Your (the Member's) name, address, and daytime telephone number;
- Your (the Member's) **[PH-MCO Name]** identification number;
- **[PH-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 Information Used to Make this Decision

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

To ask for the information used to decide your Second Level Complaint:

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

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

Mailing address:

[ADDRESS FOR REQUESTING INFORMATION USED TO MAKE A DECISION]

Help with Your Request for External Review

If you need help asking for an external review, you can call **[PH-MCO Name]** at **[PH-MCO Phone # &Toll Free TTY/PA RELAY]**.

To ask for free legal help with asking for an external review, 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]
[Service Provider, if applicable]
[Prescribing Provider, if applicable]

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]