

TEMPLATE GG(15)

**EXPEDITED GRIEVANCE DECISION NOTICE**

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

Member Name  
Address  
City, State Zip

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

Subject: Decision About Your Expedited Grievance

Dear **[Member Name]**:

**[PH-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 in detail, at a 6<sup>th</sup> grade level, every reason for denial. 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.***

**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 [PH-MCO Name].

**To ask for an expedited external review of your Grievance:**

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

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

[PH-MCO Name] will send your request to the Department of Health, which will send you more information about the expedited external review process.

<b>Ask for a Fair Hearing</b>
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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 your Fair Hearing to be decided more quickly:

You can ask for an early decision by calling the Department at **1-800-798-2339** or by faxing a letter or the “Fair Hearing Request Form” to 717-772-6328.

Your doctor or dentist must fax a signed letter to 717-772-6328 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 Member'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;
- 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  
 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 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.

**Ask for Information Used to Make This Decision**

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

To ask for the information used to decide your Grievance:

- 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 or Fair Hearing**

If you need help asking for an external review or for a Fair Hearing, you can call **[PH-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](http://www.phlp.org))

- Pennsylvania Legal Aid Network at 1-800-322-7572 ([www.palegalaid.net](http://www.palegalaid.net))

Sincerely,

**[PH-MCO Name]**

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

## 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]