

TEMPLATE GG(4)

**NOTICE FOR DENIAL OF PAYMENT AFTER A SERVICE(S) HAS BEEN  
DELIVERED BECAUSE THE EMERGENCY ROOM SERVICE(S) WAS  
NOT MEDICALLY NECESSARY**

**THIS IS NOT A BILL**

[Date Notice Mailed (date decision is made to deny payment)]

Member Name  
Address  
City, State Zip

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

Dear [Member Name]:

[PH-MCO Name] has reviewed the request from [provider's name] to be paid for [identify specific service/item] you received on [date]. Your Provider's request for payment has been denied.

The service you received was not Medically Necessary because: [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.]

[PROVIDER'S NAME] **MAY NOT BILL YOU FOR THIS SERVICE.** YOU CAN SHOW THIS NOTICE TO [PROVIDER'S NAME] IF [PROVIDER'S NAME] SENDS YOU A BILL.

Sincerely,

[PH-MCO Name]

cc: [Provider]



[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]