TEMPLATE GG(8)

FIRST LEVEL COMPLAINT DECISION NOTICE
[PH-MCO: Use if the Complaint is NOT about the following: a denial because the service or item is not a Covered Service; the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department; the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames; a denial of payment by the PH-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 PH-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Member; or a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.]

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your First Level Complaint

Dear **[Member Name]**:

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

Based on a review of all information provided, the First 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 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*..]**

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A SECOND LEVEL COMPLAINT with **[PH-MCO Name] within 45 days from the date you get this notice**. **[PH-MCO Name]** will tell you the decision on your Complaint within **[45, unless the PH-MCO will be using a shorter time frame to provide notice of 2nd level Complaint decisions]** days from when **[PH-MCO Name]** receives your Second Level Complaint.

To file a Second Level 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 #]**; or

By Mail: Mail the "Complaint/Grievance request form" or a letter to the following address:

[PH-MCO ADDRESS
FOR FILING COMPLAINT/GRIEVANCE]

To ask for an early decision

If your doctor or dentist believes that waiting **[30, unless the PH-MCO will be using a shorter time frame]** days to get a decision could harm your health, you may ask that your Complaint or Grievance be decided more quickly. For your Complaint or Grievance to be decided more quickly:

You must ask for an early decision by calling **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #],** faxing a letter to **[PH-MCO FAX #],** or by e-mailing the request to **[PH-MCO e-mail].**

Your doctor or dentist should fax a signed letter to **[PH-MCO FAX #]** within 72 hours of your request for an early decision that explains why **[PH-MCO Name]** taking **[30, unless the PH-MCO will be using a shorter time frame]** days to tell you the decision about your Complaint or Grievance could harm your health.

[PH-MCO Name] will tell you the decision within 48 hours from when **[PH-MCO Name]** gets your doctor's or dentist's letter, or within 72 hours from when **[PH-MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[PH-MCO Name]** to take more time to decide your Complaint or Grievance. You can ask **[PH-MCO Name]** to take up to 14 more days to decide your Complaint or Grievance.

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 First Level Complaint, at no cost to you.

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

- Call **[PH-MCO Name]** at **[PH-MCO Phone # &Toll Free TTY/PA RELAY]** or
- Check Box 3 on the "Complaint/Grievance request form"; or
- Write a letter.

Send the form or letter to the following:

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

Mailing address:
[ADDRESS
FOR REQUESTING INFORMATION USED TO MAKE A DECISION]

Help with Your Complaint

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

To ask for free legal help with your Second Level Complaint or with filing your Second Level Complaint, you can contact:

- 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]

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 #]**

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]