**TEMPLATE GG(9)**

# COMPLAINT DECISION NOTICE

**[PH-MCO: Use if the Complaint is 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 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 Complaint review committee has decided that **[state decision in detail]**.

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*.]**

**[PH-MCO: Include the following paragraph only if the Complaint challenges a denial because the service/item is not a covered benefit.]**

**<u>To continue getting services</u>**
If you have been getting the services or items that are being reduced, changed or denied and you ask for an external review or a Fair Hearing (see instructions below) 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.

**IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:**

## Ask for an External Review

You may ask for an "external review" of the Complaint decision from the Pennsylvania Department of Health or the Pennsylvania Insurance Department **<u>within 15 days from the date you get this notice.</u>**

To ask for an external review of your Complaint, send your request to one of the following addresses:

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

Pennsylvania Insurance Department
Bureau of Customer Service
Room 1209 Strawberry Square
Harrisburg, Pennsylvania 17120
Telephone: 1-877-881-6388

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

- Your (the Member's) name, address, and day time 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 a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. 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;
- The reason(s) you are asking for a Fair Hearing; and
- A copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for Complaints challenging a denial because a service or item is not a covered service or because the service or item was provided without authorization by a non-MA provider.]**

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 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.

**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 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.

## 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 Complaint, at no cost to you.

To ask for the information used to decide your 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 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)
- 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]**

## 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]