TEMPLATE GG(14)

GRIEVANCE DECISION NOTICE

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your 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 Grievance review committee has decided that **[state decision in detail at a 6th grade reading level]**.

The reasons for this decision are**: [Explain at a 6th grade reading level in detail every reason for decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

To continue getting services

If you have been getting services or items that are being reduced, changed, or denied and you ask for an external review or a Fair Hearing the services or items will continue until a decision is made. You must ask for an external review (see instructions below) verbally or in a letter that is hand-delivered, post marked, or faxed within 15 days from the date on this notice. Your request for a Fair Hearing (see instructions below) must be hand-delivered or postmarked within 15 days from the date on this notice.
If you ask for both an external review and a Fair Hearing, you must ask for both the external review and the Fair Hearing within 15 days from the date on this notice. If you wait to ask for a Fair Hearing until after you receive a decision on your external Grievance, services will not continue."

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 Grievance decision **within 15 days from the date you get this notice.** An external review is a review by a doctor who does not work for **[PH-MCO Name].**

To ask for an external review of your Grievance:

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

[PH-MCO ADDRESS FOR FILING COMPLAINT/GRIEVANCE]

[PH-MCO] will send your request to the Pennsylvania Insurance Department. The Insurance Department will send you more information about the external review process.

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;
- A copy of this notice;
- 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
Email: RA-PWCGFHteam@pa.gov

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.

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.

To ask for an early decision:

- Call the Department at 1-800-798-2339, or
- Email a letter or the "Fair Hearing Request Form" to RA-PWCGFHteam@pa.gov, or
- Fax 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.

Use of Email to Ask for a Fair Hearing

Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to the above address for requesting an external review or Fair Hearing.

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)
- 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 include a copy of the notice from [PH-MCO Name] with this form)

Member: _____ **Member ID:** _____

Parent/Guardian: _____ **Phone number:** _____

Address: _____

Date on Notice of Decision: _____**Managed Care Plan:**_____

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 usual time frame for a Fair Hearing decision harm your health?**
   Yes ☐ No ☐
   (See the instructions in the Grievance notice of decision about 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. **Why do you disagree with [Ph-MCO Name's] decision:** (Attach more pages if needed. You will be able to fully explain your position during the Fair Hearing)

   _____

   _____

   _____

   _____

   _____

   _____

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 if someone is helping you.)
   Representative Name and phone number: _____

   Representative Address: _____

   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
Or Email: RA-PWCGFHteam@pa.gov

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]