Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

{Replace *Denial of Medical Coverage* with *Denial of Payment*, if applicable}

**Date:** Date Denial Mailed  **Member ID or MCI number:** Enter Number

**Service Subject to Notice:** Insert Service in Question **Date of Service:** Click here to enter text.

**Effective Date of Intended Action:** Enter Date **Provider Name: (optional)** Enter Provider Name

**Name:**  Enter Name

**Address:** Enter Street Address

Enter City, State, and Zip Code

**Your Choose an item. was Choose an item.**.

We’ve Choose an item. the Choose an item. listed below:

Insert service/item/drug in question

**Why did we Choose an item. your Choose an item.?**

We Choose an item. the Choose an item. listed above because:

Click here to enter text, include rationale and alternatives

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

**You have the right to appeal** **our decision**

You have the right to ask Plan Name to review our decision by asking us for an appeal**.** If you are considering an appeal, please contact a member rights specialist for help.

**Plan Appeal:** Ask Plan Name for an appeal within **60 calendar days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an appeal with Plan Name” for information on how to ask for a plan level appeal.

**How to keep your Medicaid services while we review your case**

If you ask for an appeal before Enter effective date of intended action, you can ask that your Medicaid services not be reduced or ended until Plan Name makes a decision. You may need to pay for the extra services you received between the time you asked for your appeal and the time that Plan Name makes a decision if you lose your appeal. However, if it would cause you a large financial burden, you might not be required to repay this cost.

**If you want someone else to act for you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: Click here to enter phone number(s) to learn how to name your representative. TTY users call Click here to enter TTY number. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

**Copy of Your Case File**

You have the right to a free copy of the information in your case file related to this decision. Information means all documents, medical records, and other materials related to this decision including any new or additional information Plan Name gathers during your appeal. To request a copy of your case file, contact Enter Contact Name at Phone Number.

**Important Information About Your Appeal Rights**

**There are 2 kinds of appeals with** Plan Name

**Standard Appeal –** We’ll give you a written decision on a standard appeal regarding the Insert appropriate term within Insert appropriate term after we get your appeal. For decisions about services or items, our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. (Extensions are not available for decisions about Medicare Part B drugs). If your appeal is for payment of a Insert appropriate term you’ve already received, we’ll give you a written decision within **60 calendar days**.

**Fast Appeal** – We’ll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to Insert appropriate term for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a Insert appropriate term you’ve already received.

**We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within Insert appropriate term.

**How to ask for an appeal with Plan Name**

**Step 1:** You, your representative, or your doctor or provider must ask us for an appeal. Call specialist phone number to ask a member rights specialist to help you file an appeal. You can also start the process by sending in a request form or letter. You can get the request form fromPlan Name or one of the independent ombudsman agencies listed at the end of this document. Or you can go online and get the form at [www.dhs.wisconsin.gov/familycare/mcoappeal.htm](https://www.dhs.wisconsin.gov/familycare/mcoappeal.htm).

Your request must include:

* Your name
* Address
* Member number
* Reasons for appealing
* Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
* Any evidence you want us to review, such as medical records, doctors’ letters (such as a doctor’s supporting statement if you request a fast appeal), or other information that explains why you need the Insert appropriate term. Call your doctor if you need this information.

If you’re asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

We recommend keeping a copy of everything you send us for your records.

**Step 2:** Mail, fax, email or deliver your appeal. Or call us at the number below.

**For a Standard Appeal:** Address: Click here to enter text.

Phone: Click here to enter phone number

Fax: Click here to enter fax.

Email: Click here to enter email.

Plan Hours:

If you ask for a standard appeal by phone, we will send you a letter confirming what you told us.

**For a Fast Appeal:** Phone: Click here to enter phone number.

Fax: Click here to enter fax number.

 Email: Click here to enter email.

**What happens next?**

If you ask for an appeal and we continue to deny your request for insert “payment of” if applicable. If not applicable, delete field. a Medicare service, we’ll send you a written decision and automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

If you are appealing a Medicaid or non-Medicare covered service or support, we will not send your case to an independent reviewer. Instead, you can request a state fair hearing if you do not agree with our decision.

|  |
| --- |
| How to ask for a Medicaid State Fair HearingIf Plan Name denies your appeal request, you can take the steps listed below to request a state fair hearing. Step 1: You or your representative must ask for a state fair hearing in writing within 90 calendar days of the date of the notice that denies your appeal request. Your written request must include:* Your name
* Address
* Member number
* Reasons for requesting a fair hearing
* Any evidence you want us to review, such as medical records, doctors’ letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

**Step 2:** Send your request to:Partnership Request for Fair HearingWisconsin Division of Hearings and Appeals PO Box 7875Madison, WI 53707-7875 Fax: 608-264-9885(If not applicable, delete entire sentence) A copy of this notice has been sent to: |

**Get help & more information**

* Plan Name

Toll Free: Click here to enter toll free phone number

TTY users call: Click here to enter TTY phone number

Plan Hours:

* 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
* Medicare Rights Center: 1-888-HMO-9050
* Elder Care Locator: 1-800-677-1116 or [www.eldercare.acl.gov](https://eldercare.acl.gov/) to find help in your community.
* The Plan Name member rights specialist can inform you of your rights, try to informally resolve your concern, and assist you with filing an appeal. The member rights specialist **cannot**represent you at a meeting with Plan Name Grievance & Appeal Committee or at a state fair hearing. To contact a Plan Name member rights specialist, call specialist phone number.
* Anyone receiving Partnership services can get free help from an independent ombudsman. The following agencies advocate for Partnership members:

**For members age 18 to 59:**

**Disability Rights Wisconsin**

Toll Free: 800-928-8778

TTY: 711

**For members age 60 and older:**

**Wisconsin Board on Aging and Long Term Care**

Toll Free: 800-815-0015

TTY: 711

May insert instructions for how enrollees can receive this notice in an alternate language or format from the plan.

**PRA Disclosure Statement** According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Baltimore, Maryland 21244-1850.

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call 1‑800‑MEDICARE or email: AltFormatRequest@cms.hhs.gov