**Required Grievance and Appeal Template Language**

**Issued by the Department of Health Services (DHS) for**

**use by Managed Care Organizations (MCOs)**

As directed by the DHS-MCO contract, MCOs are required to use DHS-issued template language in certain correspondence to members regarding grievances and appeals. MCOs should copy the applicable language below and paste it into the required communication.

**Acknowledgement of grievance receipt:** MCOs are required to send an acknowledgement of receipt letter when they receive a grievance from a member. DHS does not have a template letter for this notice. DHS does require MCOs to include the following language in their notice.

**Required Language**

<<MCO name>> received your grievance on <<date>>. We have up to 90 days to resolve your grievance, and we will send you our decision by <<date the MCO received the grievance + 90 calendar days>>. If we need more than 90 days to make a decision, we will notify you in writing.

If you do not receive our decision postmarked by <<date the MCO received the grievance + 90 calendar days>>, or a notice from us telling you we need more time, you can ask for a Department of Health Services (DHS) review of your grievance. DHS contracts with MetaStar, an external quality review organization, to complete this review. Instructions about how to ask for a review are at the end of this letter.

**End of letter**:

If we do not provide you with a written decision on your grievance postmarked on or before <<date the MCO received the grievance + 90 calendar days>> you can ask MetaStar to review your grievance starting on <<date the MCO received the grievance + 91 calendar days>>. Your request for a review must be postmarked, faxed, or emailed to MetaStar **on or before** <<date the MCO received the grievance + 90 calendar days + 45 calendar days>>.

To ask MetaStar to review your grievance, call 888-203-8338. You may also ask for a DHS review by mail, fax, or email.

DHS Family Care Grievances

MetaStar

2909 Landmark Place

Madison, WI 53713

Fax: 608-274-8340
Email: dhsfamcare@dhs.wisconsin.gov

Include a copy of this notice with your request.

**Assistance: Who can help you understand this notice and your rights?**

a. The <<MCO name>> member rights specialist can inform you of your rights and assist you with filing a request for DHS review with MetaStar. The member rights specialist cannot represent you in the review process. To contact a member rights specialist, call <<Member Rights Specialist phone number>>.

b. Anyone receiving Family Care, Family Care Partnership, or PACE (Program of All-Inclusive Care for the Elderly) services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care, Family Care Partnership, and PACE 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

**Notice of extension of time to decide grievance**: MCOs are required to send a notice to a member when the MCO determines that they need more than the standard amount of time (90 calendar days) to make a decision on the member’s grievance. DHS does not have a template for this notice. DHS does require MCOs to include the following language in their notice.

**Required Language**

If you do not receive our decision postmarked by <<date the MCO received the grievance + 90 calendar days + number of additional extension days>>, you can ask for a Department of Health Service (DHS) review of your grievance. DHS contracts with MetaStar, an external quality review organization, to complete this review. Instructions about how to ask for a review are at the end of this letter.

**End of letter**:

If we do not provide you with a written decision on your grievance postmarked on or before <<date the MCO received the grievance + 90 calendar days + number of additional extension days>>, you can ask MetaStar to review your grievance starting on <<date the MCO received the grievance + 90 calendar days + number of additional extension days +1 calendar day>>. Your request for a review must be postmarked, faxed, or emailed to MetaStar **on or before** <<date the MCO received the grievance + 90 calendar days + number of additional extension days + 45 calendar days>>.

To ask MetaStar to review your grievance, call 888-203-8338. You may also ask for a review by mail, fax, or email.

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Madison, WI 53713

Fax: 608-274-8340
Email: dhsfamcare@dhs.wisconsin.gov

Include a copy of this notice with your request.

**Assistance: Who can help you understand this notice and your rights?**

a. The <<MCO name>> member rights specialist can inform you of your rights and assist you with filing a request for DHS review with MetaStar. The member rights specialist cannot represent you in the review process. To contact a member rights specialist, call <<Member Rights Specialist phone number>>.

b. Anyone receiving Family Care, Family Care Partnership, or PACE (Program of All-Inclusive Care for the Elderly) services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care, Family Care Partnership, and PACE members:

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**Grievance decision letter:** MCOs are required to make a decision on a member’s grievance and send notice to the member explaining the decision. DHS does not have a template letter for this notice. DHS does require MCOs to include the following language in their grievance decision letter.

**Required Language**

**End of letter**:

If you do not agree with our decision on your grievance, you can ask for a Department of Health Services (DHS) review. DHS contracts with MetaStar, an external quality review organization, to complete this review. MetaStar will make the final decision.

Your request for review of our grievance decision must be postmarked, faxed, or emailed to MetaStar **no later than 45 calendar days** after you receive this notice.

To ask MetaStar to review your grievance, call 888-203-8338. You may also ask for a review by mail, fax, or email.

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MetaStar

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Madison, WI 53713

Fax: 608-274-8340

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**Acknowledgement of appeal receipt:** MCOs are required to send out an acknowledgement of receipt letter when they receive an appeal from a member. DHS does not have a template for this notice. DHS does require MCOs to include the following language in their notice.

**Required Language**

<<MCO name>> received your appeal on <<date>>.

We have up to 30 days to resolve your appeal, and we will send you our decision by <<date the MCO received the appeal + 30 calendar days>>. If we need more than 30 days to make a decision, we will notify you in writing. If you do not receive our decision postmarked by <<date the MCO received the appeal + 30 calendar days>>, or a notice from us telling you we need more time, you can request a state fair hearing. Instructions about how to request a state fair hearing are at the end of this letter.

**End of letter**:

If we do not provide you with a written decision on your appeal postmarked on or before <<date the MCO received the appeal + 30 calendar days>> you can request a state fair hearing starting on <<date the MCO received the appeal + 31 calendar days>>. Your request for a state fair hearing must be postmarked or faxed to the Wisconsin Division of Hearings and Appeals (DHA) **on or before** <<date the MCO received the appeal + 30 calendar days + 90 calendar days>>.

If you ask for a state fair hearing, you will have a hearing with an independent Administrative Law Judge (ALJ). You may bring an advocate, friend, family member, or witnesses. You may also present evidence and testimony at the hearing.

<<MCO name>>’s member rights specialist can assist you with filing a fair hearing request. To contact a member rights specialist, call <<member rights specialist phone number>>. You can also get the hearing form from one of the independent ombudsman agencies listed at the end of this notice or online at [www.dhs.wisconsin.gov/library/f-00236.htm](http://www.dhs.wisconsin.gov/library/f-00236.htm).

Send the completed request form or a letter asking for a hearing and a copy of this notice to:

Family Care Request for Fair Hearing

Wisconsin Division of Hearings and Appeals

PO Box 7875

Madison, WI 53707-7875

Fax: 608-264-9885

**Assistance: Who can help you understand this notice and your rights?**

a. The <<MCO name>> member rights specialist can inform you of your rights, assist you in completing and submitting your appeal in writing and assist you with requesting a fair hearing. The member rights specialist cannot represent you at a meeting with our Grievance and Appeal Committee or at a state fair hearing. To contact a member rights specialist, call <<Member Rights Specialist phone number>>.

b. Anyone receiving Family Care, Family Care Partnership, or PACE (Program of All-Inclusive Care for the Elderly) services can get free help from an **independent ombudsman**. The following agencies advocate for Family Care, Family Care Partnership, and PACE members:

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**Required Language**

If you do not receive our decision postmarked by <<date the MCO received the appeal + 30 calendar days + number of additional extension days>>, you can ask for a state fair hearing. Instructions about how to request a state fair hearing are at the end of this letter.

**End of letter**:

If we do not provide you with a written decision on your appeal postmarked on or before <<date the MCO received the appeal + 30 calendar days + number of additional extension days>> you can request a state fair hearing starting on <<date the MCO received the appeal + 30 calendar days + number of additional extension days +1 calendar day>>. Your request for a state fair hearing must be postmarked or faxed to the Wisconsin Division of Hearings and Appeals (DHA) **on or before** <<date the MCO received the appeal + 30 calendar days + number of additional extension days + 90 calendar days>>.

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