* This model letter describes a member’s right to make an expedited grievance or “Fast Complaint” either when:
	+ The plan needs more time to make a decision on an integrated organization determination (an initial request for a service or item) or an expedited integrated appeal; or
	+ The plan denies a request for an expedited integrated organization determination or an expedited integrated appeal.
* Based on why plans are sending the letter, plans should select the appropriate language in the second paragraph of this letter.
* Instructions to plans appear in *blue italicized text and brackets [ ]* and are only for plan use. Plans must ensure that no blue text remains in the letter that plans send to members.
* Plans must revise references to “Medicaid” to use the state-specific name for the program throughout the letter. If the state-specific name does not include the word “Medicaid,” plans should add “(Medicaid)” after the first reference of the state-specific name.
* Plans may modify the letter as needed to describe the plan’s rules and benefits.
* Plans may modify the language in the letter, as applicable, to address state-specific Medicaid benefits and procedures.
* Where the template instructs inclusion of a phone number, plans should insert the most appropriate plan number. Only the plan’s Member Services phone and TTY numbers are required to be toll-free.
* If plans do not use the term “Member Services,” plans should replace it with the term they use.
* Plans should ensure plan-customized text is in plain language.
* Plans may place a hyperlink or a QR code in the letter where appropriate to provide an option for members to go online.

**Your Right to Make a Fast Complaint**

<Date of Letter>

[*Insert Member name*]

Member Health Plan ID: [*Insert member ID*]

Service/item this letter is about: [*Insert name of service/item]*

Member *Medicaid ID*: [*Insert Medicaid ID*]

<Plan name> is called “our plan” or “we” in this letter. We are a health plan that contracts with Medicare and Family Care Partnership (Medicaid) to provide coverage for both programs. Our plan coordinates your Medicare and Family Care Partnership services and your doctors, hospitals, pharmacies, and other health care providers.

[*Insert one of the following sets of paragraphs as applicable:*]

[*When plan needs more time to make a decision:* **Our plan needs more time to make a decision about your <request** *or* **appeal> for the <service** *or* **item> listed above.** We may need up to **14 more calendar days** to give you a decision.

If you disagree with our plan’s decision to take more time to give you a decision, **you or your <doctor** *or***health care provider> can make a fast complaint.**

* You may need a faster decision because of a health or medical reason.
* If you need a faster decision, ask your <doctor *or* health care provider> to send us information about your health or medical reason.
* When you make a fast complaint, our plan must give you a decision on your fast complaint **within 24 hours**.
* If our plan agrees you need a faster decision, we’ll make a decision about your <request *or* appeal> sooner.]

*[OR]*

[*When plan denies request for expedited integrated organization determination/appeal:* **Our plan reviewed your <request for <service** *or***item> listed above** *or***appeal for <service** *or***item> listed above, and we don’t think you need a fast <decision** *or***appeal> because** [*Insert a concise explanation for the plan’s decision****.*** *Write the explanation in plain language and give, at a minimum, a basic explanation of the reasoning behind the action in the simplest language possible without losing meaning.*].

Our plan will make a decision about your <request *or* appeal> by **[*Insert specific decision deadline date in month, date, year format – 14 calendar days for requests (72 hours for Part B drugs)/30 calendar days for appeals (7 calendar days for Part B drugs) from date that the request or appeal was made. Insert deadline date in bold text.*]**.

If you disagree with our plan’s decision that you don’t need a fast <decision *or* appeal>, **you or your <doctor** *or* **health care provider> can make a fast complaint.**

* You may need a faster decision because of a health or medical reason.
* If you need a faster decision, ask your <doctor *or* health care provider> to send us information about your health or medical reason.
* When you make a fast complaint, our plan must give you a decision on your fast complaint **within 24 hours**.
* If our plan agrees you need a faster decision, we’ll make a decision about your <request *or* appeal> sooner.]

# How to make a fast complaint

Contact our plan as soon as possible to make a fast complaint. Usually, **calling our plan’s <name of individual/department responsible for receiving fast complaints> is the first step** for making a fast complaint. We **must respond within 24 hours of getting your fast complaint.**

* To make a fast complaint by phone, you or someone you have named as your representative to act on your behalf (such as a relative, friend, or lawyer) may call <plan phone number for fast complaints> (TTY: <TTY number>), <days and hours of operation>.
* When you call, tell us you want to make a fast complaint.
* If you make your fast complaint by phone, our plan may call you to give you our answer and follow up with a written response.

You always have the right to make a fast complaint in writing if you don’t want to call <name of individual/department responsible for receiving fast complaints>.

* To put your fast complaint in writing, you or your representative can mail us at <plan mailing address>, send a fax to <plan fax number for fast complaints>, or email us at <plan email address>.
* If you make your fast complaint in writing, our plan will send you a written response.

You also have the right to ask for a written response from our plan when you call to make a fast complaint.

# Get help and more information

* **<Plan name> <Name of individual/department responsible for receiving fast complaints>:** Call <toll-free plan phone number for fast complaints> (TTY: <toll-free TTY number>), <days and hours of operation>. You can also visit <plan website>.
* <**Plan name> Member Rights Specialist**: Call <member rights specialist phone number> (TTY: <TTY number>). The member rights specialist can answer your questions and help you submit a fast complaint.
* **Independent Ombudsman:** Anyone receiving Family Care Partnership services can get free help from an independent Ombudsman. The following agencies advocate for Family Care Partnership members:

**For members age 18 to 59:**

**Disability Rights Wisconsin**

Toll Free: 800-928-8778

TTY: 711

[www.disabilityrightswi.org/learn/family-care-and-iris-ombudsman-program/](http://www.disabilityrightswi.org/learn/family-care-and-iris-ombudsman-program/)

**For members age 60 and older:**

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

Toll Free: 800-815-0015

TTY: 711

<http://longtermcare.wi.gov/section_detail.asp?linkcatid=1953&linkid=1014&locid=123>

* **Wisconsin State Health Insurance Assistance Program (SHIP):** Call 800-242-1060 (TTY: 711). Medigap Helpline counselors can help you with Medicare issues, including how to make a fast complaint. They aren’t connected with any insurance company or health plan. Their services are free. <http://longtermcare.wi.gov/category.asp?linkcatid=1958&linkid=1014&locid=123>
* **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit [Medicare.gov](http://www.Medicare.gov).
* **Medicaid Member Services** Call 1-800-362-3002.
* **Medicare Rights Center:** Call 1-800-333-4114, or visit [www.medicarerights.org](http://www.medicarerights.org/).
* **Eldercare Locator:** Call 1-800-677-1116, or visit [www.eldercare.acl.gov](http://www.eldercare.acl.gov) to find help in your community.
* **Aging and Disability Resource Center (ADRC):** Visit [www.dhs.wisconsin.gov/adrc/consumer/index.htm](http://www.dhs.wisconsin.gov/adrc/consumer/index.htm) to find the ADRC nearest to you.

You can get this document for free in other formats, such as large print, braille, or audio. Call <toll-free phone and TTY numbers, days and hours of operation>. The call is free.

[*Plans are subject to the notice requirements under Section 1557 of the Affordable Care Act. For more information, visit* [*www.hhs.gov/civil-rights/for-individuals/section-1557*](http://www.hhs.gov/civil-rights/for-individuals/section-1557).]