Model Notice 11
Grievance Response

Organizational Letterhead

[Date]

Member Information

[Member Name or Legal Guardian]
[Street Address]
[City, State, Zip]

Member Name: [Patient Name]
Member DOB: [Patient DOB]
Medicaid ID: [Patient ID]

Grievance Response

Why am I getting this letter?

We got a grievance from you on [Date MCO Received the Grievance].

[Description of Grievance: Summarize the Member's grievance and identify the type of grievance that applies—administrative, emergency medically-related, or non-emergency.]

Resolution Explanation

A [MCO] Representative title, credentials and/or qualifications, and specialty] reviewed your grievance and responded on [date of decision].

[Provide description of grievance response in easy-to-understand language. If the grievance was an emergency medically-related grievance or resolved over the phone, add date of resolution call or notification.]

Next Steps

If we did not respond to you by [date of decision], you can appeal. Call [MCO phone #] or the Maryland Department of Health's HealthChoice Help Line at 1-800-284-4510.

Questions or Need Help?

First, please read the Appeal and Grievance Rights fact sheet with this letter. The fact sheet has more information about your rights and responsibilities under Maryland law.

If you have questions, call us at [MCO phone #] or the HealthChoice Help Line at 1-800-284-4510.

Sincerely,

[MCO Designee]
[MCO]
cc: Appropriate Parties (any individuals or entities required to be notified)

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Enclosures
Appeal and Grievance Rights
Non-Discrimination Statement
Language Accessibility Statement