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?**

Read the Appeal and Grievance Rights fact sheet with this letter. The fact sheet explains your rights and responsibilities under Maryland law.

For 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)

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