Model Notice 1
Denial of Services

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]

Denial of Services

Why am I getting this letter?
You or your provider asked us to provide [Specify medical service(s) or treatment in plain language].
A [MCO's name] representative reviewed your case and decided:

_____ This service is approved but for less than what you and your provider requested. The next section explains why we made this decision.

_____ The service(s) your provider requested is/are not medically necessary. The next section explains why we made this decision.

_____ The service(s) your provider requested is/are no longer medically necessary. The next section explains why we made this decision.

_____ The service(s) your provider requested is/are not a covered Medicaid benefit. The next section explains why we made this decision.

____ This service might be covered, but not by [MCO Name]. Your provider should seek payment directly from the Maryland Department of Health's fee-for-service Medical Assistance Program (red/white card). For more information, please call Maryland's HealthChoice Help Line at 800-284-4510 or the Maryland Medicaid Pharmacy Access Hotline at 1-833-325-0105. See the next section for more details.

How did we make this decision?

Our [MCO] representative [add reviewer's name or initials, title, credentials, and/or qualifications] reviewed your case using nationally recognized medical standards.

[Give a clear, full, and factual explanation of the reasons for denial, reduction, or termination and exact clinical guideline reference in easy-to-understand language. Also, include any missing information that the provider needs to submit for the service to be approved.]

Call [MCO Member Services] or [MCO phone #] (TTY) if you want a free copy of any guideline, code, record, benefit provision, protocol, or any document we used to make this decision. You can also ask for your medical records free of charge.

Next Steps

If you do not agree with this decision, you can:

(1) Have your provider talk to our provider, or ask for an appeal.

- Your provider can talk with our provider representative about this decision. To do this, your provider can call [MCO phone #] and ask for a peer-to-peer review. Your provider has X days from the date of this notice, or [Deadline Calendar Date to Request Peer-to-Peer], to request this review.
    - ***Please Note:*** *You can request a peer-to-peer review for medical necessity denials only.*

(2) You or your representative can ask for an appeal by calling [MCO phone #] or writing to [insert address]. You have 60 days from the date of this letter, or until [Deadline Calendar Date to File Appeal – 60 Days from Date of Letter], to send your appeal. Appeals take up to 30 days for us to decide.

- **If a representative asks for an appeal for you, you need to give us permission in writing to process the appeal**. A representative is someone who has written permission to act or speak for you, like a family member, a friend, a provider, or a lawyer. Sign and send us the "Authorized Representative for Member Appeal Form". You can mail, fax, or email us the form with this letter.

If you, your provider, or your representative believes the appeal needs a faster review because of your health, call [MCO phone #] and ask for a faster review time.

- If we agree, we will decide and contact you and your provider within 3 days of your request.
- If we do not agree to your request for a faster review, we will contact you and your provider to let you know why and decide within 30 days.
- If you do not agree with our decision not to do a faster review, call [MCO phone #] to send a grievance. You can also call the Maryland Department of Health's HealthChoice Help Line at 1-800-284-4510.

(3) Call the Maryland Department of Health's HealthChoice Help Line.

- Call the HealthChoice Help Line at 1-800-284-4510 to learn how to appeal this denial. The HealthChoice Help Line representative will connect you with a nurse consultant who can help you.

Can I continue getting services if I ask for an appeal?

Yes. If you are getting these services and they are about to end, you might be able to keep getting them during the appeal. Call us at [MCO phone number] by [10 Days from Date of Letter] or before the last day of your services to ask for the services to continue. Your provider cannot make this request for you.

But if you lose the appeal, you might need to pay for these services.

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: Requesting Provider
Primary Care Provider (optional)

Enclosures
Appeal and Grievance Rights
Non-Discrimination Statement
Language Accessibility Statement
Authorized Representative for Member Appeal Form