Model Notice 2
Appeal Confirmation

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]

Appeal Confirmation

Why am I getting this letter?

You or your representative asked us on [date of filed appeal] to appeal our decision on [date of action] to deny [specify medical services or treatment in plain language].

[*Insert this text **only** if the member requests continuation of benefits*:] **You also asked to keep receiving these services while we review your appeal. If we still deny the services you appealed, you might have to pay for the services.]**

*[Insert this text **only** if an authorized rep form has not been received:]* **We need your written permission to let someone else appeal for you by [Date for member to provide written permission]. Fill out and sign the Authorized Representative for Member Appeal Form. You can mail, fax, or email it to us.**

Next Steps

We are now reviewing your appeal. The person who reviews your appeal will be different from the person who denied it. We will decide in 30 days, or no later than [Date -30 days from date of filed appeal].

During the appeal, you can:

- Request a copy of your medical records and any guidance or information used to make the initial decision.
- Send more information to help us decide.
- Arrange to talk to us about the appeal. Please let us know if you would like to talk to us about the appeal in person or virtually within 5 days of the date of this letter, or by [Date – 5 days from date of letter].

For any of these options, call us at [MCO phone #] or [MCO phone #] (TTY). Someone will assist you.

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Can I continue receiving services during the 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] before the last day of your services. 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

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