

*Organizational Letterhead*

[Date]

**Member Information**

[Member Name or Legal Guardian]

Member Name: [Patient Name]

[Street Address]

Member DOB: [Patient DOB]

[City, State, Zip]

Medicaid ID: [Patient ID]

**Appeal Confirmation**

**Why am I getting this letter?**

On [date of filed appeal], you or your representative appealed our decision 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 deny the services you appealed, you may have to pay for the services.**

*[Insert this text **only** if an authorized rep form has not been received:]* You must give us written permission by [date] if you want someone else to appeal for you. **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. We will assign someone new to review your appeal. **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 written comments, documents, or other information to support your appeal.
- 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) or write us at **[insert fax # and address]**. Someone will assist you.

*[Insert this text **only** if the member has not requested a continuation of benefits in their appeal.]*

**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.

**Only you can make this request.**

Model Notice 2  
Appeal Confirmation

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

**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: Requesting Provider

Enclosures

Appeal and Grievance Rights

Non-Discrimination Statement

Language Accessibility Statement

Authorized Representative for Member Appeal Form