Model Notice 3
Appeal Timeframe Expiration

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 Timeframe Expiration

Why am I getting this letter?

We got a request on [date of filed appeal] to appeal our decision on [date of action] to deny [Specify medical services or treatment in plain language].

[Date of Deadline for Filing Appeal] was the deadline for filing an appeal. You did not send your request in time. We will not process your appeal request.

Next Steps

Call [MCO phone #] to send a grievance. You can also call the 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: Requesting Provider

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