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 Dismissal

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].

Based on the reason selected below, we are dismissing the appeal.

[_] You missed the appeal deadline. [Date of Deadline for Filing Appeal] was the last day to file.

[_] We did not get the written consent needed for your provider or representative to file an appeal for you.

[_] You or your authorized representative withdrew your appeal on [date of conversation with member/representative]. We agreed to stop reviewing your case. This letter confirms our agreement.

[ ] We approved the service before getting your appeal request.

[ ] Other: [Enter reason for dismissal.]

Next Steps

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

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