Model Notice 5
Denial of Faster Review

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 Faster Review

Why am I getting this letter?

On [date of filed appeal], you or your representative asked to appeal our decision on [date of action] to deny [specify medical services or treatment in plain language]. You or your representative also asked us for a faster review time on [Date of Request for Expedited Appeal].

We decided not to do a faster review because [Provide a clear, full, and factual explanation of the reasons for the decision in easy-to-understand language].

If you want a free copy of any guideline, codes, records, benefit provision, protocol, or any document used to make the decision, call the [MCO Member Services] at [MCO phone #] or [MCO phone #] (TTY).

Next Steps

A representative will decide on the appeal within 30 days of the date you sent it, or [Date - 30 days from date of filed appeal]. The person who reviews your appeal will be different from the person who denied it.

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

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,

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[MCO Designee]
[MCO]
Cc: Requesting Provider

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