Model Notice 6
Appeal Extension

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 Extension

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].

We need more time to decide because [Provide a clear, full, and factual explanation of the reasons in easy-to-understand language].

Next Steps

A [MCO] Representative title, credentials and/or qualifications, and specialty] will make a decision within 14 calendar days of the initial appeal resolution date, or [date of extended appeal deadline].

If you do not agree with our decision to extend the appeal, 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,
[MCO Designee]
[MCO]
Cc: Requesting Provider

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