Model Notice 7
Appeal Extension Request Confirmation

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 Request Confirmation

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 asked for more time. Your initial appeal decision date was [Initial Resolution Date].

Next Steps

A [MCO] Representative's the person's title, credentials and /or qualifications, and specialty], added 14 calendar days to your initial appeal decision date, and will notify you and your provider with our decision by [date of extended appeal deadline]. You, your provider, or your representative can send us more information during this time.

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 [MCO] 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