Model Notice 9
Appeal Decision- Reversed Denial

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 Decision- Reversed Denial

Why am I getting this letter?

On [date of appeal filing], you or your representative asked for an appeal. A [MCO] representative reviewed the appeal and decided to reverse the denial for [specify medical services or treatment in plain language]. The request for [specify medical services or treatment in easy-to-understand language] is now approved.

How did we make this decision?

[MCO Representative's name or initials, the person's title, credentials and/or qualifications, and specialty] made this decision on [Date of decision]. They based the decision on [Provide 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 similar information used to decide your appeal, including your medical records, call the [MCO Member Services] at [MCO phone #] or [MCO phone #] (TTY).

Next Steps

The services or benefits that were denied before are now approved. Contact your provider for next steps.

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