

Organizational Letterhead

[Date]

Member Information

[Member Name or Legal Guardian]

Member Name: [Patient Name]

[Street Address]

Member DOB: [Patient DOB]

[City, State, Zip]

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 [MCO] 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?

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]

Model Notice 9
Appeal Decision- Reversed Denial
Cc: **Requesting Provider**

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