TEMPLATE GG (9)

COMPLAINT DECISION NOTICE

[PH-MCO: Use if the Complaint is about the following: a denial because the service or item is not a Covered Service; the failure of the PH-MCO to provide a service or item in a timely manner, as defined by the Department; the failure of the PH-MCO to decide a Complaint or Grievance within the specified time frames; a denial of payment by the PH-MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the Medical Assistance Program; a denial of payment by the PH-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Member; or a denial of a Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.]

[Date Notice Mailed (date of the Complaint decision)]

Member Name
Address
City, State Zip

Member ID: *********

Subject: Decision About Your Complaint

Dear **[Member Name]**:

[PH-MCO Name] has reviewed your Complaint about **[issue],** received on **[date]**.

Based on a review of all information provided, the Complaint review committee has decided that **[state decision in detail at a 6th grade reading level]**.

The reasons for this decision are: [**Explain at a 6th grade reading level in detail every reason for decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

[PH-MCO: Include the following paragraph only if the Complaint challenges a denial because the service/item is not a covered benefit.]

To Continue Getting Services

If you have been getting services or items that are being reduced, changed, or denied and you ask for an External Review or a Fair Hearing **within 15 days from the date on this notice** the services or items will continue until a decision is made. Instructions for how to ask for an External Review or a Fair Hearing are included below. If you ask for both an External Review and a Fair Hearing, you must ask for both the External Review and the Fair Hearing within 15 days from the date on this notice. If you wait to ask for a Fair Hearing until after you receive a decision on your External Review, services will not continue.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR BOTH OF THE FOLLOWING:

Ask for an External Review

You may ask for an "external review" of the Complaint decision from the Pennsylvania Insurance Department **within 15 days from the date you get this notice.**

To ask for an external review of your Complaint, send your request to the following:

Pennsylvania Insurance Department
Bureau of Consumer Services
Room 1209, Strawberry Square
Harrisburg, PA 17120
Fax: 717-787-8585

or

Go to the "File a Complaint Page" at
https://www.insurance.pa.gov/Consumers/Pages/default.aspx

Your request for an external review by the Insurance Department must include the following information:

- Your (the Member's) name, address, and day time telephone number;
- Your (the Member's) **[PH-MCO Name]** identification number;
- **[PH-MCO Name]**'s name
- A brief description of the issue;
- A copy of this notice.

If you need help filing your request for external review, call the Bureau of Consumer Services at 1-877-881-6388.

Ask for a Fair Hearing

You may ask for a Fair Hearing from the Department of Human Services. Your request for a Fair Hearing must be in writing and must be received by the Department of Human Services or postmarked **within 120 days from the date on this notice.** You can either fill out and sign the "Fair Hearing Request Form" or write a letter.

If you write a letter, it needs to include the following information:

- Your (the Member's) name and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- The reason(s) you are asking for a Fair Hearing;
- A copy of this notice;
- A copy of the original denial notice, if available. **[PH-MCO: Include this last item only for Complaints challenging a denial because a service or item is not a covered service or because the service or item was provided without authorization by a non-MA provider.]**

Send your request for a Fair Hearing to the following address:

Department of Human Services
OMAP – HealthChoices Program
Complaint, Grievance and Fair Hearings
P.O. Box 2675
Harrisburg, Pennsylvania 17105-2675
Fax: 1-717-772-6328
Email: RA-PWCGFHteam@pa.gov

The Department will make a decision within 90 days from when you filed your Complaint with **[PH-MCO Name]**, not including the number of days between the date on this notice and the date you asked for a Fair Hearing. The Department will send you a decision in writing.

To ask for an early decision

If your doctor or dentist believes that waiting the usual time frame for deciding a Fair Hearing could harm your health, you may ask that the Fair Hearing take place more quickly.

To ask for an early decision:

- Call the Department at 1-800-798-2339, or
- Email a letter or the "Fair Hearing Request Form" to:
  - RA-PWCGFHteam@pa.gov, or
- Fax a letter or the "Fair Hearing Request Form" to 717-772-6328.

Your doctor or dentist must fax a signed letter to 717-772-6328 explaining why taking the usual amount of time to decide your request for a Fair Hearing could harm your health. If your doctor or dentist does not send a letter, your doctor or dentist must testify at the Fair Hearing to explain why taking the usual amount of time to decide your request for a Fair Hearing could harm your health.

The Department will schedule a telephone hearing and tell you its decision within 3 business days from when it receives your request.

Use of Email to Request a Fair Hearing

Because emails are not secure unless encrypted by the sender, you should not include personal identifying information such as your date of birth or personal medical information unless you encrypt the email when requesting a Fair Hearing. You may send a request for a Fair Hearing through email and provide your personal identifying information in a letter mailed to RA-PWCGFHteam@pa.gov.

Ask for Information Used to Make this Decision

You or your representative may ask **[PH-MCO Name]** to see any information **[PH-MCO Name]** used to decide your Complaint, at no cost to you.

To ask for the information used to decide your Complaint:

- Call **[PH-MCO Name]** at **[PH-MCO Phone # &Toll Free TTY/PA RELAY]** or
- Mail or fax a letter requesting the information to the following:

Fax number: **[PH-MCO FAX #]**

Mailing address:
[ADDRESS FOR REQUESTING INFORMATION USED TO MAKE A DECISION]

Help with Your Request for External Review or Fair Hearing

If you need help asking for an external review or for a Fair Hearing, you can call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**.

To ask for free legal help with your external review or Fair Hearing, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[PH-MCO Name]

cc: **[Member Representative, if designated]**
[Service Provider, if applicable]
[Prescribing Provider, if applicable]

FAIR HEARING REQUEST FORM
(Please include a copy of the notice from [PH-MCO Name] with this form)

Member: _____ **Member ID:** _____

Parent/Guardian: _____ **Phone number:** _____

Address: _____

Date on Notice of Decision: _____ **Managed Care Plan:**_____

1. **Check how you would like to be present your Fair Hearing**

   ☐ **BY TELEPHONE** (You will be sent the date and time of the Fair Hearing. You will be called at the phone number above)

   ☐ **IN PERSON** (You will be sent the date, time, and location of the Fair Hearing)

2. **Will waiting the usual time frame for a Fair Hearing decision harm your health?**
   Yes ☐ No ☐
   (See the instructions in the Complaint notice of decision about how to ask for an early decision.)
3. **Do you need an interpreter or language services? Yes ☐ No ☐ Language?**_____
   (Interpreter and language services will be provided free of charge)
4. **Why do you disagree with [PH-MCO Name's] decision:** (Attach more pages if needed. You will be able to fully explain your position during the Fair Hearing.)

   _____

   _____

   _____

   _____

   _____

   _____

5. **If someone will be helping you with your Fair Hearing, please provide their information:**
   (If you don't yet have anyone helping you, just leave this blank and you can let he Department of Human Services know later if someone is helping you.)
   Representative Name and phone number: _____

   Representative's Address: _____
   Relation to Member: _____

Signature: _____**Date:**_____

Send to: Department of Human Services
OMAP- HealthChoices Program
Grievance, Appeal, and Fair Hearings
P.O. Box 2675
Harrisburg, PA 17105-2675

Or Fax: 1-717-772-6328
Or Email: RA-PWCGFHteam@pa.gov

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]