TEMPLATE GG(14)

GRIEVANCE DECISION NOTICE

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

Member Name
Address
City, State Zip

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

Subject: Decision About Your Grievance

Dear **[Member Name]**:

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

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

The reasons for this decision are**: [Explain in detail, at a 6th grade level, every reason for the decision. In addition to explanation for decision, paraphrase references to approved criteria, rules, and/or protocols on which the decision is based. *If under the age of 21, denial must be based on medical necessity. If a member under the age of 21 is denied because of insufficient information to determine medical necessity, it must be clear that a medical necessity determination could not be reached with the available information and all information needed to render a decision must be listed. If denied because of insufficient information and 21 or older, identify all additional information needed to render decision*.]**

To continue getting services
If you have been getting the services or items that are being reduced, changed or denied and you ask for an external review (see instructions below) verbally or in a letter that is hand-delivered or postmarked **within 10 days from the date on this notice**, the services or items will continue until a decision is made or if you ask for a Fair Hearing (see instructions below) and your request is hand-delivered or postmarked **within 10 days from the date on this notice**, the services or items will continue until a decision is made.

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 Grievance decision **within 15 days from the date you get this notice.** An external review is a review by a doctor who does not work for **[PH-MCO Name].**

To ask for an external review of your Grievance:

By Phone: Call **[PH-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**; or

By Mail: Send a letter to the following address:

[PH-MCO ADDRESS FOR FILING COMPLAINT/GRIEVANCE]

[PH-MCO] will send your request to the Pennsylvania Department of Health. The Department of Health will send you more information about the external review process.

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 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; and
- The reason(s) you are asking for a Fair Hearing;
- A copy of this notice;
- A copy of the original denial notice, if available

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

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. For a decision to be made more quickly:

You can ask for an early decision by calling the Department at **1-800-798-2339** or by faxing 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.

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 Grievance, at no cost to you.

To ask for the information used to decide your Grievance:

- 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 send in a copy of the notice you are requesting a Fair Hearing about, along with this form)

Member: _____ **Member ID:** _____

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

Address: _____

Date on the Notice of Decision: _____

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 normal time frames harm your health? Yes ☐ No ☐**
   (See the instructions on your notice on 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. **Tell us why you disagree with our decision:** (Attach more pages if needed.)

   _____

   _____

   _____

   _____

   _____

   _____

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 The Department of Human Services know later.)
   Representative Name and phone number: _____

   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

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]