

**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

## **Notice of Denial of Medical Coverage**

{Replace *Denial of Medical Coverage* with *Denial of Payment*, if applicable}

---

**{This section must be provided in core language areas per OHP rules for client with language other than English as primary}**

This information is about a service or treatment your health care provider recently asked us to cover or pay for. We have denied this request. You have the right to ask us to change our decision.

### **You have the right to appeal our decision to us for both Medicaid and Medicare denials.**

You must file an appeal request **within 45 days for Medicaid** from the Date of Notice listed on the enclosed Notice and **within 60 days for Medicare** from the Date of Notice listed on the enclosed Notice.

Please call us at the phone number on the enclosed Notice right away if:

- You do not understand the Notice.
- You need the Notice in large print, a different format or language. An interpreter will translate the document at no cost to you.

### **You may complete ONE form to us to request both the Medicare and Medicaid Appeal.**

**If you want to also request a State Medicaid Hearing, you will need to complete the enclosed hearing request form and send it to the State.**

**Additional details about both appeals and hearing processes and your rights are included in this notice.**

### **Important Information About Continuing Services**

To keep getting this service while you wait for your Appeal or Hearing, you must:

- Already have been getting the service before it was denied,
- Ask for an Appeal and/or Hearing **within 10 days from the “Date of Notice” or by the “Effective Date” shown on the Notice**, whichever is later.
- Request for Medicaid services to be continued by checking Box 4 on the enclosed Oregon Medical Assistance Programs Appeal and Hearing Request }, and/or the enclosed {Plan Name} Appeal Form.

If we do not change our decision or the hearing judge supports our decision, you may have to pay for services you get after Effective Date of Notice.

---

**Member Name:** [Client Name]  
**Oregon Health Plan ID Number:** [OHP Client ID]  
**Medicare ID Number:** [Medicare Client ID]  
**Date of Birth:** [Client DOB]  
**PCP/PCD:** [PCP/PCD Name]  
**Requesting Provider Name:** [Doctor Name]

**Date of Notice:**  
**Effective Date:**

[Insert other identifying information, as necessary (e.g., provider name, enrollee's Medicaid number, service subject to notice, date of service)]

Dear [Client Name Here]

---

## Your request was denied

On [Date] , [Doctor Name] asked us to cover [Description of the service or item requested]. We've {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} medical services/items listed below requested by you or your doctor [*provider*]:

---

---

This request was reviewed by our Medical Director or designee. Unfortunately, [Medicare Plan Name] and [CCO Name ] are unable to approve this request.

## Why did we deny your request?

### A) Medicare Denial

We {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} medical services/items listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

---

---

### A) Medicaid Denial

We {Insert appropriate term: *denied, stopped, reduced, suspended*} the {*payment of*} medical services/items listed above because [Provide specific rationale for decision]. This decision is based on Oregon Administrative Rule(s) (OAR) [provide the legal citation (rule, regulation, statute), including specific references to applicable sections or subsections, that corresponds to each reason provided above for denying the claim] .

In addition, the following administrative rules are also applicable to our decision: OAR 410-120-0000; OAR 410-141-0000; OAR any additional rule or other law that substantially relevant to the decision, including specific references to applicable sections or subsections..

You may get the information we used in making this decision in writing. To get a copy, call Customer Services at 555-555-5555 or 555-555-5555 TTY, Monday to Friday, 8 am - 5 pm.}:

## **You have the right to appeal our decision to us for both Medicaid and Medicare denials.**

You have the right to ask {health plan name} to review our decision by asking us for a Medicare or Medicaid services {payment} appeal and/or you can request a State Fair Hearing. You can ask for both types of review at the same time, as long as you meet the deadlines.

If you ask us for an appeal first, you may miss the deadline for requesting a State Fair Hearing.

**Appeal:** Ask {health plan name} for a Medicaid services {payment} denial appeal **within 45 days**. You can do this by requesting an Appeal, a Hearing, or both. Ask {health plan name} for a Medicare services {payment} denial appeal **within 60 days** of the date of this notice. A late request may only receive consideration if you have a good reason.

### **State Fair Hearing**

- You may ask for a State Fair Hearing *within 45 days* of the date of this notice. A late request may be given consideration only if you have a good reason for being late.
- You may file both an appeal with the plan and ask for a state fair hearing at the same time.

### **Continuation of Services During An Appeal or Hearing Request**

If we're stopping or reducing a service, you can keep getting the service while your case is being reviewed. If you want the service to continue, you must ask for an appeal (Insert, if applicable: or a State Fair Hearing) **within 10 days** of the date of this notice or before the service is stopped or reduced, whichever is later. Your provider must agree that you should continue getting the service. If you lose your State Fair Hearing or appeal, you may have to pay for these services.

### **If you want someone else to act for you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: {number(s)} to learn how to name your representative. TTY users call {number}. *Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us.*

## **Important Information About Your Appeal Rights**

### **There are 2 kinds of appeals**

**Standard Appeal** – We'll give you a written decision on a standard appeal **within 30 days for Medicare** decisions and **14 days for Medicaid decisions** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If we need more time, we will send a written notice to let you know it will take an extra 14-16 days beyond the Medicaid or Medicare standard appeal timeframe. If your appeal is for payment of a service you've already received, we'll give you a written decision for Medicare appeals within **60 days**.

**Fast Appeal** – We'll give you a written decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 days for a decision.



## ***How to ask for a Medicaid State Fair Hearing***

*[You have the right to ask for a State Fair Hearing without asking us (health plan) to review our decision first.]*

**Step 1:** *You or your representative must ask for a State Fair Hearing (in writing) within 45 days of the date of this notice. If you have a good reason for your request being late, please include information in your letter on why you are late. A late request will only be considered if you have a good reason for being late.*

*Your {written} request must include:*

- Your name
- Address
- Member number
- Reasons for appealing
- Any evidence you want us to review, such as medical records, doctors' letters, or other information that explains why you need the item or service. Call your doctor if you need this information.

**Step 2:** *Send your Medicaid Services hearing request to*

Address: Medical Assistance Programs

Attention: Hearings Unit

500 Summer St. NE, E49

Salem, OR 97301-1079

Phone: 503-945-5785

Fax: 503-945-6035

### **What happens next?**

*The State will hold a hearing. You may attend the hearing in person or by phone. You'll be asked to tell an administrative law judge why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. Before the hearing a Medical Assistance Programs (MAP) staff member will call you to get more information and explain what will happen during the hearing.*

*The following people will participate in the hearing with you:*

- A MAP Hearings representative;*
- Someone from your plan;*
- Your representative or helper (if you have one);*
- An administrative law judge; and*
- Any witnesses you invite.*

*You'll get a written hearing decision within 30 days. The written decision will explain if you have additional appeal rights.*

[A copy of this notice has been sent to:]

