[Denial Notice Header]

[Enrollee Name] [Date]
123 Main Street
Anytown, LA 71111

Dear [Parent/Guardian or Enrollee Name]:

We are writing to tell you that your request for [service and dates of service] is denied and [Plan Name] will not pay for the care.

To find out why we won't pay, keep reading. If you think we made a mistake, you may ask for an appeal.).

We will not pay for [denied service and dates of service], but [Plan Name] will pay for the following care (if your doctor prescribes it):

1. List service and date of service that is approved
2. List service and date of service that is approved

~~If you are not already getting these services and you think you need them, talk to your doctor.~~

If you have questions, call [Plan Name] at **1-800-xxx-xxxx. TTY users call 1-800-xxx-xxxx. This call is free.** Your doctor also got a copy of this letter, so you should also talk to your doctor.

Commented [DL1]: FONT REQUIRMENTS, as per the settlement:
•Must be 12 point or greater.
•Must not be in all caps

Beyond that – font type can be different from the template, as long as it is easily readable; bolded terms in the template do not have to be bolded, though it is strongly encouraged that headers be bolded; italics are discouraged

Commented [DL2]: Include a header at the top of the page above the body of the letter that indicates if services are denied, partially denied or approved.

Commented [DL3]: Include a salutation – "Dear member or parent or guardian of member" and a closing/signature at the end of the letter.

Commented [KS4]: Make sure service is written in plain language and be as specific as possible. Don't just use a general categorization of what type of service it is.

Commented [DL5]: Must use the term "denied" or "denial" or "partial denial" or "partially denied" in the introductory paragraph.

Commented [DL6]: MCOs must include internal appeal language in the denial. State Fair Hearing language should be included in the appeal denial letter.

Commented [KS7]: If the service is provided in increments (hours per week/day, milligrams for pharmacy, etc.) that needs to be indicated.

Commented [DL8]: This section should only be used in a partial denial letter. Full denial letters should omit this whole section.

Commented [LW9]: This is no longer needed.

Commented [DL10]: Keep phone number formatting consistent throughout. DHH prefers you include the "1" prior to the 800 number.

Why won't [Plan Name] pay for [service]?

This section should include a comprehensive explanation in plain language for why the request does not meet the guidelines for care. It should include ALL criteria and reasons for the denial. Do not limit to just one reason if there are multiple.

At a minimum, the Plan should include the following:

- *What criteria the Plan used to make the determination (requests made, medical records reviewed, etc.).*
- *References to rules, regulations and guidance (federal and state) used to make the decision. Include numbers for reference of rules and a clear explanation of how the guidance relates to this particular case.*
- *What guidelines the member does not meet, including a plain language explanation of medical necessity, as applicable.*
- ~~*Who reviewed the request (doctor name) and a*~~ *A summary of the activity that helped to make the decision about their care.*
- *Where appropriate, break apart technical and complex information with bullets or numbering to make the information more readable and use clearly stated headers that will draw the member's attention.*
- *Summarize that, because of all the reasons stated, the Plan does not think the care is medically necessary.*

Do you have questions? Call us at **1-800-XXX-XXXX.** You may also want to talk to your doctor.

Commented [DL11]: MCOs must comply with contractual guidance on continuation of services pending resolution as per Section 13.5.2.7 of their contract. This language is not prescribed in the template, but must be included as applicable. Insert where appropriate..

Does your doctor want to talk to someone about this decision? Your doctor can call [Health Plan Reviewer Name) at 1-XXX-XXX-XXXX.

What can you do if you think [Plan Name] made a mistake?

If you think we made a mistake, you may ask for a fair hearing (also called an appeal). If you want to request a fair hearing, you must do so within 30 days from receipt of this notice.

Commented [DL12]: The State Plan requires 30 days from receipt of the notice, so do not include an actual date.

What happens if you ask for a fair hearing?

- You tell [Plan Name] why you think the decision about your care is incorrect.
- A meeting is scheduled so your case can be heard by a judge.
- You attend the meeting and present information you think will prove that the decision is incorrect. You can have someone attend the meeting and help you with the appeal process.
- Until a decision is made about your fair hearing, we will only pay for services that you're already approved to get.

How do you ask for a fair hearing?

Give us all of the information listed here:

Your name	
Your address	

Your telephone number	
Your date of birth, Social Security number, or member ID number	
The kind of care you think you qualify to receive	

Send your request to the Division of Administrative Law – Health and Hospitals Section.
You can file a State Fair Hearing request by phone, fax, mail or on the web.
Mail: P.O. Box 4189
Baton Rouge, Louisiana 70821-4189
Fax: (225) 219-9823
Phone: (225) 342-5800
Web: http://www.adminlaw.state.la.us/HH.htm

How long does it take to make a decision about my fair hearing?
Most decisions are made within 90 days of asking for a fair hearing.

What if you need a fast decision?
If your condition is considered urgent, we may be able to make a decision about your appeal much sooner. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

- You will be at risk of serious health problems, or you may die;
- You will have serious problems with your heart, lungs, or other body parts; or
- You will need to go into a hospital.

Your doctor must agree that you have an urgent need.

Do you need help with this letter? Call [Plan Name] at **1-800-XXX-XXXX.**

If you need help in another language, call 1-888-xxx-xxxx (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al **1- 888-xxx-xxxx** o TDD/TTY **1-877-xxx-xxxx**, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số **1-866-595-8133** hoặc TDD/TTY **1-877-xxx-xxxx** trong khoảng từ 8 giờ sáng - 5 giờ chiều.

Commented [DL13]: All Health Plans must use these contacts for State Fair Hearings.

Commented [DL14]: For all MCOs, the first denial notice letter must include the internal appeals process, not the State Fair Hearing Process. OMIT this section and replace it with your appeal process language.

MCOs must comply with contractual guidance on State Fair Hearing inclusion in their notices of action (Section 13.5.2.4). This full section must be included with appeal denial letters.

Commented [DL15]: This language is new – replacing the "emergency" language from the previous letter. Use this language in this section and avoid use of the word "emergency".