Notice of Denial

[Date]

To the Parents or Guardian of:
[Enter Member's First and Last Name]
[Member's Address]
[Member's City, State Zip Code]

Dear Parents or Guardian of **[Member's Name]:**

We are writing to tell you that your request for [**amount of service**] Community Psychiatric Supportive Treatment (CPST) and [**amount of service**] Psychosocial Rehabilitation Services (PSR) for **[Dates of Service]** is denied and **[Contractor 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.

If you have questions, call **[Contractor Name]** at **[1-XXX-XXX-XXXX] or [TDD/TTY XXX]. This call is free.** Your doctor also got a copy of this letter, so you can also talk to your doctor.

Why won't [Health Plan] pay for CPST and PSR for [Dates of Service]?
[This section should include a comprehensive explanation in plain language for why the request does not meet the guidelines/criteria for care. It should include ALL guidelines/criteria for the denial and how they were applied to the member's case. The guidelines/criteria should be a hyperlink per HB424/ACT 330.]

[General notice guidance:

- *Explain considerations that played a role in determination of hours or amounts of service*
- *Explain facts considered for denial.*
- *The denial explanation should tie back to the guidelines and/or provider's reasons for the request as denoted in the supporting documentation.*
- *Avoid using only age as justification for denial*
- *If a child is denied for cognitive reasons explain why members' specific cognitive abilities don't meet necessary standards.*
- *Use bullet points, as applicable, to make the explanation to keep the denial explanation clear and concise.]*

Because of all the reasons stated, **[Contractor Name]** does not think the care is medically necessary.

You or someone legally authorized to do so, can ask for a **free** copy of the criteria, guidelines or any other information we used to make this decision by calling **[1-XXX-XXX-XXXX].**

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

Does your doctor want to talk to someone about this decision? Your doctor can talk to the doctor who made this decision by calling **[1-XXX-XXX-XXXX].**

What can you do if you think [Contractor Name] made a mistake?
If you think we made a mistake, you may ask for an appeal. If you want to request an appeal, you must do so within 60 calendar days from date of this notice. You can choose to file an appeal yourself, or you can choose another person, including an attorney or your doctor, to act on your behalf. If your doctor or someone else appeals for you, you must give them written permission before requesting an appeal.

How do you ask for an appeal?
There are three ways you can ask for an appeal:

- **Call [Contractor Name]** at **[1-XXX-XXX-XXXX]**
  - Your signed, written appeal request must be received following the call.
- **Mail the Request for Appeal form to:**
  Contractor Name
  Contractor Address
  Contractor City, State, Zip

3. **Fax** the Request for Appeal form to [**1-XXX-XXX-XXXX]**

How long does it take to make a decision about my appeal?
We will review your appeal and send a written decision within 30 calendar days of our receipt of your appeal.

What if you need a fast decision?
If your condition is considered urgent, we may be able to make a decision about your appeal within 72 hours of receipt. 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.

State Fair Hearing
Once you have completed **[Contractor Name]** appeal process, and you still disagree with our decision, you can request a State Fair Hearing. Instructions on how to file a State Fair Hearing will be sent with your appeal decision letter.

How do I continue to receive this service during my appeal?
If you are already receiving this service, you have the right to continue benefits while an appeal is in process. You must ask for this within 10 calendar days from the date of this notice by calling **[Health Plan]** at **[1-XXX-XXX-XXXX]**. If the appeal decision or State Fair Hearing agrees with the denial, you may have to pay the cost of the service you received.

Do you need help with this letter? Call [Health Plan] at [1-XXX-XXX-XXXX], [TTY XXX].
If you need help in another language, call [**1-XXX-XXX-XXXX], [TTY XXX]** (toll-free).

Para obtener ayuda para traducir o entender esta información, sírvase llamar al **[1-XXX- XXX-XXXX, TTY XXX]**, entre 7 a.m. y 7 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số **[1-XXX-XXX-XXXX]** hoặc **[TDD/TTY XXX]** trong khoảng từ 7 giờ sáng - 7 giờ chiều.

Sincerely,

[Reviewer Name, Title]
[Health Plan]

Enclosure:

cc: **[Provider Name]**