[MCO Name/Logo in Header]

Notice of Denial

[Date]

To the Parents or Guardian of:
[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 Pediatric Day Health Care (PDHC) **[include other services, if applicable]** for dates of service **[Dates of Service]** is denied and **[Health Plan]** 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 **[MCO]** 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 [MCO] pay for PDHC [include other services, if applicable – should match services identified in introductory paragraph] for [Dates of Service]?

The name of the criteria and/or regulation used to make the decision is: **Pediatric Day Health Care Provider Manual [and/or the name of the criteria/policy/regulation used and its hyperlink].**

The specific reason for the decision is: Your child's doctor asked for PDHC **[include other services, if applicable]**. According to the criteria above your child must meet all of the following:

- Have a medically complex condition;
- Needs skilled nursing care; and
- Requires any type of therapy by a licensed nurse on an ongoing basis to:
  - preserve and maintain health;
  - prevent death;
  - treat or cure disease;

- improve disabilities or other adverse health conditions; and/or prolong life.
- Be stable for outpatient medical services in a home or community-based setting.

We reviewed the following records from **[Provider Name]** submitted on **[Date]**. The records show:

- [Denote the needs identified in the documentation submitted by the provider and why they are inappropriate for skilled nursing care. Sufficiently describe the considerations that played a role in the denial while still using plain language.]

These are only some of the medical needs that would qualify for PDHC Services. Other needs not listed can make someone eligible for PDHC.

Based on the PDHC Provider Manual and medical records reviewed, you do not meet the criteria for PDHC. Because of all the reasons stated, Health Plan does not think the care is medically necessary.

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 [Health Plan] 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 the date of this notice.

To file an appeal, you can call us at **[1-XXX-XXX-XXXX], [TTY XXX]** or you can send your appeal to:

[Health Plan]
Attn: Grievances & Appeals Department
[Address] [City,
State, Zip]

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.

You can do the appeal yourself, or you can choose someone else to do the appeal for you. Your representative can be someone you trust such as a lawyer, a family member or friend. You, your representative, or your doctor also has the right to give us information about your appeal.

That information can be in person or in writing. You or your representative can also see your case file both before and during the 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 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. We will review your appeal and send a written decision within 72 hours of our receipt of your appeal.

State Fair Hearing
Once you have completed **[Health Plan's]** 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.

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]

CC: [Provider Name]