[Company Header/logo and/Vendor Header/logo, if applicable]

[Denial Notice]
[Date]

[Enrollee Name]
Street Address
City, LA Zip Code

Dear [Parent/Guardian or Enrollee Name]:

We are writing to tell you that your request for **[amount of service, *if applicable*]** for **[service and date(s) of service] is [denied]** and **[Contractor Name]** will not pay for the care. ([Vendor Name] reviews prior authorization for [service] on behalf of [Contractor Name], *if applicable*).

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. TTY users call 1-XXX-XXX-XXXX. This call is free.** Your doctor also got a copy of this letter, so you should also talk to your doctor.

Why won't [Contractor Name] pay for [amount of service, *if applicable*] for [service]?

According to the LA Department of Health Medicaid contract and federal regulations **(42 CFR 438.404 and 438.210)** requests for prior authorizations must be denied if a decision is not made within the standard timeframe of 14 calendar days. If your provider requested an expedited prior authorization and it was determined that your life, health or ability to keep or regain full function could be seriously harmed by waiting the standard 14 calendar days, a fast decision was is due within 72 hours of receipt of your request.

The prior authorization request for **[service]** was received on **[date received]** and the decision was due on **[14 calendar days OR 72 hours after receipt of the request for service]. Contractor name]** was unable to make a decision within the required timeframe. Therefore, the request for **[service]** is denied. If you believe you were eligible to receive this service, you may present evidence at an appeal that you met the medical criteria to get the service.

Commented [BA1]: Corrected spelling.

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.** You may also want to talk to your doctor.

[Contractor address, phone, web address, etc.]

Does your doctor want to talk to someone about this decision? Your doctor can call **[Contractor Name]** at **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?
1. Call [Contractor Name] at **1-XXX-XXX-XXXX**.
2. 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.

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 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:

1. You will be at risk of serious health problems, or you may die;
2. You will have serious problems with your heart, lungs, or other body parts; or
3. 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 **[Contractor Name]** at 1-800-123-4567. 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 **[Contractor Name]** at **1-XXX-XXX-XXXX.**
If you need help in another language, call 1-XXX-XXX-XXXX (toll-free). **[Contractor address, phone number, web address, etc.]**

Para obtener ayuda para traducir o entender esta información, sírvase llamar al 1- XXX-XXX-XXXX o TDD/TTY 1-XXX-XXX-XXXX, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số 1-XXX-XXX-XXXX hoặc TDD/TTY 1-XXX-XXX-XXXX.

Sincerely,
[Contractor Name]

Enclosure: Request for Appeal Form

cc: Your Provider, MD
Best Medical Care Center