|  |  |
| --- | --- |
|  | **PLAN ID: XXXXXXXXXXXXXXXXXXXX** |

<<HEALTH PLAN>>

<<STREET ADDRESS>>

<<CITY, STATE ZIP>>

<<DATE>>

<<ENROLLEE>> and/or

<<LEGAL REPRESENTATIVE>>

<<STREET ADDRESS>>

<<CITY, STATE ZIP>>

**NOTICE OF PLAN APPEAL RESOLUTION**

Dear <<ENROLLEE/ LEGAL REPRESENTATIVE>>:

On <<DATE PLAN APPEAL REQUEST RECEIVED>> we received your timely plan appeal request regarding <<PLAN>>’s Notice of Adverse Benefit Determination dated <<DATE OF NABD>>, NABD Number ACME-16-000156, <<PARTIALLY DENYING, DENYING, TERMINATING, SUSPENDING, REDUCING>> the <<SERVICE/ AMOUNT>> provided to <<ENROLLEE>>.

On <<DATE PLAN APPEAL PROCESS RESOLVED>>, after consideration of the information you provided to <<PLAN>> in support of your plan appeal, <<PLAN>> hereby <<PARTIALLY DENIES, DENIES, APPROVES >> your plan appeal. As a result, <<ENROLLEE>> will receive <<SERVICE/AMOUNT>>, effective <<DATE >>

You, or someone legally authorized to do so, can ask us for a complete copy of your file, including medical records, and other documents, records, and other information considered during the plan appeal process. These will be provided free of charge.

**What to Do if You Disagree with the Plan Appeal Decision**

If you do not agree with this decision, you have the right to request a review from the state. When you ask for a review, a hearing officer who works for the state reviews the decision made during the plan appeal.

**How to Ask for a Review by the State**:

You may ask for a review by the state any time up to 120 days after you get this Notice of Plan Appeal Resolution. Your case manager can help you with this, if you have one.

You may ask for a review by the state by calling or writing to:

Agency for Health Care Administration

Medicaid Hearing Unit

P.O. Box 60127

Ft. Myers, FL 33906

(877) 254-1055 *(toll-free)*

239-338-2642 *(fax)*

[MedicaidHearingUnit@ahca.myflorida.com](mailto:MedicaidHearingUnit@ahca.myflorida.com)

Your written request must include the following information:

* Your name
* Your member number
* A phone number where we can reach you or your authorized representative

You may also include the following information if you have it:

* Why you think we should change the decision
* Any medical information to support the request
* Who you would like to help with your fair hearing

After getting your request, the Agency for Health Care Administration (Agency) will tell you in writing that they got your request.

If you have questions, call us at <<PHONE>> or <<TTY NUMBER>>. For more information on your rights, review the Grievance and Appeal section in your Member Handbook. It can be found online at: <<WEB ADDRESS>>.

**Notice of Nondiscrimination**

<< INSERT NONDISCRIMINATION LANGUAGE>>

Sincerely,

<<NAME>>

<<Medical Director or title of the other professional who made the adverse benefit determination in accordance with Attachment II, Section VII.E.1. of the SMMC contract>>