|  |  |
| --- | --- |
|  | **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, a copy of plan review criteria and guidelines, contract provisions, other documents, records, and other information considered during the plan appeal process. These will be provided free of charge.

You may request these documents by contacting: <<Plan supplied contact information>>

**Right to Request a State Medicaid Fair Hearing**

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

**How to Ask for a Fair Hearing**:

You may ask for a fair hearing 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 fair hearing 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 for a Medicaid fair hearing must include the following information:

* Your name
* Your member number
* Your Medicaid ID 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 fair hearing request, the Agency for Health Care Administration (Agency) will tell you in writing that they got your fair hearing request.

**How to Ask for Your Services to Continue During a Fair Hearing:**

If you were receiving services during your plan appeal, file the request for your services to continue with the Agency **no later than 10 days** from the date on this Notice of Plan Appeal Resolution OR on or before the first day that your services are scheduled to be reduced, suspended, or terminated, *whichever is later*.

If your services are continued and our decision is upheld in a fair hearing, we may ask that you pay for the cost of those services. We will not take away your Medicaid benefits. We cannot ask your family or legal representative to pay for the services.

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 other professional who made the plan appeal decision and who was not the decision maker or the subordinate of the decision maker in the previous level of review, per 42 CFR 438.406(b)(2)(i)>>