

NOTICE OF GRIEVANCE RESOLUTION

<SUD PROVIDER name and logo>

Important: Read this notice carefully. If you need help, you can call one of the numbers listed on the next page under "Get help & more information."

Mailing Date: <Mailing Date>

Member ID: <SUD PROVIDER ID Number>

Name: <Member's Name>

Beneficiary ID: <Medicaid ID Number>

This Notice is in response to a request that we received on <date received>

You Filed a Grievance

We took your concerns seriously. Thank you for taking the time to bring this to our attention.

Your grievance concerned <subject of grievance> and involved <short summary of grievance>.

We have reviewed your grievance and an independent reviewer completed the review on <completion date>, which was <number of days> days from when your grievance was received.

Based upon our review we reached the following conclusion:

The action(s) which has/will be taken based upon your grievance:

MEDICAID FAIR HEARING

Medicaid enrollees have access to the State Fair Hearing process regarding Grievances when the provider fails to resolve the grievance and provide the notice of the Grievance Resolution within **90 calendar days** from the date of the initial grievance request. Customer Service would be happy to provide you a State Fair Hearing request form if the date of this letter is more than **90 calendar days** from the date of the initial grievance request or to assist you in any other way.

ACCESS TO DOCUMENTS

You and/or your authorized representative are entitled to reasonable access to and a free copy of all relevant documents. You can make a document request by contacting Customer Services at the number below.

Get help & more information

**If you need additional help or do not understand any part of this Notice, please call
<SUD PROVIDER> Customer Service Department**

<phone number>

For those with hearing impairment, please call Michigan Relay at 7-1-1 for assistance.

<hours of operation>

You can also visit our website at <website>

Michigan Department of Health and Human Services (MDHHS) Beneficiary

Help Line: 1-800-642-3195. TTY users call 1-866-501-5656 or

1-800-975-7630 (if calling from an internet-based phone service).

Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.
