

NOTICE OF ADVERSE BENEFIT DETERMINATION

<CMHSP name and logo>

Important: This notice explains your internal appeal rights. Please read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under “Get help & more information.”

Mailing Date: <Mailing Date>

Member ID: <CMHSP ID Number>

Name: <Member’s Name>

Beneficiary ID: <Medicaid ID Number>

This is to tell you that the following action has been taken:
[Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates]
This action is based on the following:
[Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

IF YOU DON’T AGREE WITH OUR ACTION, YOU HAVE THE RIGHT TO AN INTERNAL APPEAL

You have to ask <CMHSP> for an internal appeal within 60 calendar days of the date of this notice. You, your representative or your doctor can send in your request that must include:

- Your Name
- Address
- Member number
- Reason for appealing
- Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
- Any evidence you want us to review, such as medical records, doctors’ letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor’s supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

There are 2 kinds of internal appeals:

Standard Appeal: We'll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within 60 calendar days.

If you want to ask for an Internal Appeal either call or send in a written request to:

<CMHSP>
<Address>
<City, State, Zip>
<Phone Number>
<Fax Number>

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

Expedited or "Fast" Appeal: Expedited or Fast Appeal – We'll give you a decision on a fast appeal within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting up to 30 calendar days for a decision. We'll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll give you a decision within 30 calendar days.

To ask for a Fast Appeal, you must call: <Phone Number>

CONTINUATION OF SERVICES DURING AN INTERNAL APPEAL

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination <insert 10 calendar day date>, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending, and should submit your request to the <CMHSP>

Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

IF YOU WANT SOMEONE ELSE TO ACT FOR YOU

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: <number(s)> to learn how to name your representative. TTY users call 7-1-1. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You'll need to mail or fax this statement to us. Keep a copy for your records.

ACCESS TO DOCUMENTS

You and/or your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

WHAT HAPPENS NEXT?

- If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
- The Notice of Appeal Denial will give you additional information about the State Fair Hearings process and how to file the request.
- If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Office of Administrative Hearings and Rules.

Get help & more information

**If you need additional help or do not understand any part of this Notice, please call
<CMHSP> 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).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.
