NOTICE OF RECEIPT OF GRIEVANCE

<CMHSP 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: <CMHSP 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 received your grievance on <date received> about <subject of grievance>. We take your concerns seriously. Thank you for taking the time to bring this to our attention.

What this means

We will review your grievance by <date received plus 90 calendar days>. A letter will be mailed to you within two (2) calendar days after we complete our investigation telling you what we found and what (if any) action we will take, or have taken.

If you want someone to represent you

At any time during the process you may have another person act for you or help you. This person will be your representative. If you want someone to act for you, you must tell us that in writing.

If you already have someone to represent you, or if you have a legal guardian, power of attorney, or someone authorized to make health care decisions on your behalf, you do not have to do anything else.

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).

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