# NOTICE OF RECEIPT OF APPEAL

## <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."

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**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>.**

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## You Filed an Internal Appeal

We received your request for an internal appeal on <date received>. You are appealing our decision to <description of subject of appeal>.

## What this means

A decision on this appeal will be made by <date received plus thirty (30) days>. A letter will be mailed to you telling you what our decision is and why we made that decision.

<The appeal was received within ten (10) calendar days of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the appeal is being reviewed.> 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 qualified for continuation of benefits during your internal appeal and you ask for a State Fair Hearing from MOAHR within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later. MOAHR must receive your State Fair Hearing by <insert 10 calendar day date from this notice> and you should state in your request that you are asking for your service(s) to continue.

We may contact you for more information or if we have more questions. If you have any questions or additional information to provide, please call <list an appeals specific phone number/fax number>.

## 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>**

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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.**