MODEL MLTC/MMC EXTENSION NOTICE (Revised 11/21)
FOR SERVICE AUTHORIZATION REQUESTS OR APPEALS

Template begins below this line

[MCO/MLTC OR DUAL LETTERHEAD FOR PLAN AND UR AGENT/BENEFIT MANAGER]
[Plan Name] [UR AGENT/Benefit Manager Name]
[Address]
[Phone]

REVIEW EXTENDED

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee Number: [ID number or CIN]
Coverage Type: [Insert coverage type]
Service: [describe requested or claimed service including: amount/duration/date of service]
Provider: [requesting provider]
Plan Reference Number: [plan reference number]

Dear [Enrollee]:

On [Date of Request] you [asked [Plan Name] for [service]] {*or*} [asked for a Plan Appeal about [service]]. [[UR Agent Name] on behalf of] [Insert Plan Name] is reviewing your request. **You are getting this notice because we need more information and are extending our review until [Date].**

We feel this is best for you because: [explanation of how the delay is in the best interest of the Enrollee].

To review this request, we need the following information: [Additional information required]

If this information is not received by [Date] we will make a decision based on the information we have.

Please mail or fax the requested information to:

[Contact Name]
[Plan/UR Agent Name]
[Address]
[City, State Zip]
Fax: [1-800-MCO PLAN]

{*Insert when extension is for an appeal*} [If we do not make a decision by [EXPDate], you may ask the State for a Fair Hearing. You can call 1-800-342-3334 or fill out the form online at http://otda.ny.gov/oah/FHReq.asp to ask for a Fair Hearing.]

If you disagree with our decision to extend review of your [request][Plan Appeal], you or your designee may file a complaint by calling [1-800-MCO PLAN] or writing to [Plan/UR Agent Address]. A decision will be made within 45 days after receipt of all necessary information but no more than 60 days from receipt of the complaint.

Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling {for MMC} [1-800-206-8125] {or for MLTC}[1-866-712-7197].

{*Insert for all MLTCP/MAP/HARP; Insert for MA/MMC/HIV SNP only when services are LTSS or Delete*}[You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

{*Insert for MA/MMC/HIV-SNP for non-LTSS Services or Delete*} [For advice about your coverage or help filing a complaint or appeal, you can contact Community Health Advocates (CHA) at:

Community Health Advocates (CHA)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service**: 711)
Web: www.communityhealthadvocates.org | **Email**: cha@cssny.org]

Are you having trouble getting the substance use disorder or mental health services that you need? The Community Health Access to Addiction and Mental healthcare Project (CHAMP) is an ombudsman program that can help you with insurance rights and getting coverage for your care. CHAMP can help! Contact:

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service:** 711)
Web: https://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ
Email: ombuds@oasas.ny.gov

You can call [PLAN NAME] at 1-800-MCO-PLAN if you have any questions about this notice. {*Insert as applicable*}[To talk to someone at [Insert UR Agent] call [Insert UR Agent Number].]

Sincerely,

[MCO/UR AGENT/BENEFIT MANAGER Representative]

cc: Requesting Provider

{*Insert as applicable*} [Enrollee Representative(s)]

NOTICE OF NON-DISCRIMINATION

[PLAN NAME] complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[PLAN NAME] provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
ملحوظة: إذا كنت تتحدث اللغة العربية فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل بالرقم <TTY/TDD رقم هاتف الصم والبكم> toll free number	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD>	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں تو آپکو زبان کی مدد کی خدمات مفت میں دستیاب ہیں کال کریں <TTY toll free number>.	Urdu