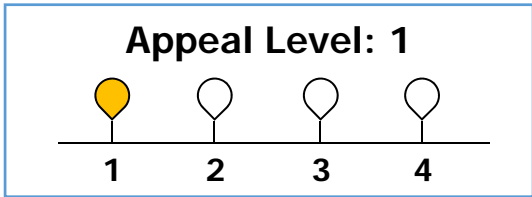


Important: This notice explains your appeal rights. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information." Oral interpretation is available for all languages. Access these services by calling <phone number>.

[FIDA PLAN NAME/LOGO]



[An Acknowledgement of Appeal notice must accompany this notice]

WE CANNOT GIVE YOU A FAST (OR "EXPEDITED") APPEAL

Name:

Date of Notice:

Participant Number:

[Insert other identifying information, as necessary (e.g., provider name, Participant's Medicaid number, service subject to notice, date of service)]

Dear <Participant name> ,

On <date appeal received, orally or in writing,> at <hour received> you, or someone acting for you, requested a fast (or "expedited") appeal for the following action: *[Insert a brief description of the FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved.]*

We denied your request for a fast appeal

Your request for a fast appeal (also known as an "expedited" appeal) was denied because you did not prove that a standard appeal could seriously risk your life, health, or ability to function. The reasons for our decision are as follows: *[Insert specific rationale for the decision, and include any clinical rationale that explains why it was decided that the standard timeframe would not jeopardize the participant's life, health or ability to regain maximum function or stay in their home or other residence. Also indicate that the Participant and his/her representative, if applicable, may request the relevant clinical review criteria at no cost to them.]*

You may file a fast grievance

If you think we made a mistake in denying your request for a fast appeal, you or someone acting for you can file a fast grievance (also known as an “expedited” grievance) to ask us to reconsider. We will respond to your grievance within 24 hours.

Step 1 – Gather your information and materials. You will need the following:

- Your name
- Your date of birth (or other identifying information, like your Participant number)
- Your contact information (for example: your phone or mailing address)
- Reason(s) why you need a fast appeal
- Any evidence or information that you want us to review to support your need for a fast appeal (for example: medical records, doctors’ letters, or other information that explains your need. Call your doctor or Care Manager if you need this information.)

[If the plan requires any specific information to address the grievance, insert the following text:]

Please submit the following specific information to help us reach our decision on your grievance:

Step 2 – Send the information and materials by mail, fax, or phone. You can also deliver it in person, or give it to your Care Manager.

Grievance Contact Information:

Phone <phone number>
Regular Mail <address>
Fax <fax number>
Delivery in Person <address>
Contacting your Care Manager <phone number>

You will receive a standard appeal

Because we denied your request for a fast appeal, you will receive a standard appeal. This is Level 1 of the appeal process. Please refer to the “Acknowledgement of Appeal” notice enclosed with this letter to learn more about:

- The appeal review process
- How to request an in-person or phone-based review
- How to request transportation or an in-home review
- How to get your case file
- How to submit evidence
- How to choose a representative
- How to get free and independent information and advice about your case

Contact us immediately if you did not receive your "Acknowledgement of Appeal" notice, or if you have any questions about these topics.

<Plan name>

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

[Plans must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:]

A copy of this notice has been sent to: <name>
<address>
<phone number>

Get help & more information

(TTY users call 711, then use the phone numbers below)

- <Plan name>
Toll Free Phone: <phone number>
<hours of operation>
- Independent Consumer Advocacy Network (ICAN)
<http://icannys.org>
Email: ICAN@cssny.org
Toll Free Phone: 1-844-614-8800
8:00am – 8:00pm, Monday – Sunday
- Health Insurance Information, Counseling and Assistance Program (HIICAP)
Toll Free Phone: 1-800-701-0501
- 1-800-MEDICARE (1-800-633-4227)
TTY users call: 1-877-486-2048
24 hours a day, 7 days a week
- NYS Department of Health
Bureau of Managed Long Term Care
Toll Free Phone: 1-866-712-7197
- Medicare Rights Center
Toll Free Phone: 1-888-HMO-9050

<Plan's legal or marketing name> is a managed care plan that contracts with both Medicare and the New York State Department of Health (Medicaid) to provide benefits of both programs to Participants through the Fully Integrated Duals Advantage (FIDA) Demonstration.

You can get this information for free in other languages. Call <toll-free number> and <TTY/TDD numbers> during <hours of operation>. The call is free. *[This disclaimer must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

You can also ask for this information in other formats, such as Braille or large print.

The State of New York has created a participant ombudsman program called the Independent Consumer Advocacy Network (ICAN) to provide Participants free, confidential assistance on any services offered by <plan name>. ICAN may be reached toll-free at 1-844-614-8800 or online at icannys.org.