[FIDA PLAN NAME/LOGO]

Appeal Level: 1

NON-PARTICIPATING PROVIDER NOTICE OF APPEAL DECISION DELAY

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 <Non-Participating Provider name>,

On <date appeal received, orally or in writing> [*for expedited appeals insert:* at <hour received>] you, or someone acting for you, appealed 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.*]

[*Insert the following section if the Participant (or his/her representative) requested the extension:*]

You asked us to delay our appeal decision

You, or someone representing you, requested more time before <plan name> makes its decision on your appeal. We received your extension request on <date>. You requested more time because: [*Give a brief description of the request. Include the reason or purpose of the extension, if known.*]

Due to this request, we extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. If you no longer want the extension, call <plan name> immediately at: <phone number>. TTY users call <TTY number>.

[*Insert the following section if the plan initiated the extension:*]

We delayed our appeal decision

We extended our decision deadline by <number of days (up to 14 days)>. That means we will make a decision on your appeal by <date>. We delayed the decision because: [*Explain why the decision was delayed. For example, the receipt of additional medical evidence from noncontract providers may be crucial to the appeal decision.*]

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This delay is in your interest and is allowed by federal regulation.

What we need from you

To help us decide your appeal, please submit the following information or materials: [*Request any items from the Non-Participating Providerwhich may have prompted the delay, e.g. witness statements, non-network provider records, etc.*]

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Send the information or materials by mail, fax, or phone to:

<Plan name>
<Name of Appeals/Grievance Department>
<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>
Fax: <fax number>

If you want someone to represent you

You can have someone else represent you during your appeal.

If you already named someone to represent you when you requested this appeal, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, both you and the person you want to act for you must sign and date a statement confirming this is what you want. Send your letter or form to us by fax or mail.

[*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>