

[FIDA PLAN NAME/LOGO]

Appeal Level: 1

NON-PARTICIPATING PROVIDER APPEAL DECISION NOTICE

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> ,

<Plan name> reviewed your appeal, received on <date appeal received, orally or in writing> *[for expedited appeals insert: at <hour received>]*, about the following action: *[Insert a detailed description of the FIDA Plan action/IDT decision (e.g. denial, reduction, PCSP renewal, etc.) being appealed and the benefits involved (provide more detail than the Appeal Acknowledgement letter). Also, include the original rationale for the FIDA Plan action/IDT decision that is the basis of the appeal.]*

Level 1 Appeal decision

The appeal was decided in your favor on <date of appeal decision>. That means we *[Insert as applicable: reversed or modified]* the previous decision made on <date of plan coverage determination or PCSP update, as applicable>.

What this means

Because our Level 1 Appeal decision is fully in your favor, you are authorized to receive the following services as of <date authorized (no later than one business day after the FIDA Plan appeal decision date)>: *[List the services that were approved, including any applicable information about coverage amount, duration, etc.]*

[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>