**Notice of Receipt of Your Appeal/Grievance Request**

**[CMHSP/PIHP/SUD Agency Name]**

**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.”

**Mailing Date:** <Mailing Date> **Member ID:** <Member’s ID Number>

**Name:** <Member’s Name> **Beneficiary ID:** <Member’s Medicaid ID Number>

**This Notice is in response to a request that we received on [date received].**

**You Filed A Grievance**

Your Grievance was received on [date received] about [subject of grievance]. Your concerns are taken seriously. Thank you for taking the time to bring this to our attention.

**WHAT THIS MEANS**

Your Grievance will be reviewed by [date received plus **90 calendar days**]. A letter will be mailed to you within **2 calendar days** after the investigation is completed telling you what was found and what (if any) action will be taken or have been taken.

**You Filed an Internal Appeal**

Your request for an Internal Appeal was received on [date received]. You are appealing the decision to [description of subject of Appeal].

**WHAT THIS MEANS**

A decision on your Internal Appeal will be made by [date received plus **30 calendar days**]. A letter will be mailed to you telling you what the decision is and why that decision was made. [The Internal Appeal was received within **10 calendar days** of the decision that you are appealing. Therefore, the service(s) you have been receiving may continue while the Internal 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/PIHP/SUD Agency Name.)

Your benefits for that service will continue if you qualified for continuation of benefits during your Internal Appeal and ask for a State Fair Hearing within **10 calendar days** from the date of this notice or from the intended effective date of the proposed Adverse Action, whichever is later. The MAHS 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. You may be contacted for more information or if questions need to be answered. If you have any questions or additional information to provide, please call [list an Internal Appeals specific phone number and/or fax number].

**FOR BOTH GRIEVANCES AND APPEALS (If you want someone to represent you)**

At any time during the Internal Appeals process, you may have another individual act for you or help you. This individual 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:**

• [CMHSP/PIHP/SUD Agency Name]: If you need help or additional information about the decision and the Internal Appeal process, call Member Services at: [telephone number]; TTY: [TTY telephone number], [hours of operation].

* 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).

[*Add language and disclaimer notice requirements under Section 1557 of the Affordable Care*

*Act. For more information, refer to* [*https://www.hhs.gov/civil-rights/for-individuals/section-1557.]*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)