**NOTICE OF ADVERSE BENEFIT DETERMINATION**

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

**Important:** This notice explains your Internal Appeal rights. Read this notice carefully. If you need help with this notice or asking for an Appeal, you can call one of the numbers listed on the last page under “Get help & more information.”

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

**Effective Date:<** Date Action will occur>

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

**This is to tell you that the following action has been taken:** *[Enter information regarding the Adverse Benefit Determination taken to deny, reduce, suspend, or terminate a covered benefit or payment with effective dates]*

**This action is based on the following:**

[*Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.*]

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

**If you do not agree with our action, you have the right to an Internal Appeal.**

You must ask [CMHSP/PIHP/SUD Agency Name] for an Internal Appeal within **60 calendar days** of the date of this notice. You, your representative, or your physician/provider can send in your request that must include:

• Your Name

• Your Address

• Your Member Number

• Your Reason for Appealing

• Whether you want a Standard or Expedited Appeal (for an Expedited Appeal, explain why you need one)

• Any evidence you want us to review, such as medical records, letters from your physicians, or other information that explains why you need the item or service. If you are asking for an Expedited Appeal, you will need a physician’s supporting statement. Call your physician if you need this information.

Please keep a copy of everything you send us for your records.

**There are 2 kinds of Internal Appeals: Standard Appeal:**

You will be given a written decision on a Standard Appeal within **30 calendar days** after your Appeal is received. Our decision might take longer if you ask for an extension, or if we need more information about your case. You will be told if extra time is being taken and will receive an explain why more time is needed. If your Appeal is for payment of a service you have already received, you will receive a written decision within **60 calendar days**. If you want to ask for an Internal Appeal, you can either call or send a written request to:

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

**[Address]**

**[Phone Number TTY Phone Number] [Fax Number]**

**Expedited Appeal:**

You will be given a decision on an Expedited Appeal within **72 hours** after your Appeal is received. You can ask for an Expedited Appeal if you or your physician believe your health could be seriously harmed by waiting up to **30 calendar days** for a decision. **You will automatically be given an Expedited Appeal if your physician asks for one for you or if your physician supports your request.** If you ask for an Expedited Appeal without support from your physician, the State will decide if your request requires an Expedited Appeal. If you are not given an Expedited Appeal, you will be given a decision within **30 calendar days**. To ask for an Expedited Appeal, you must call: **[Phone Number] [TTY Phone Number]**

**Continuation of services during an Internal Appeal:**

If you are receiving a Michigan Medicaid service and you file your Appeal within **10 calendar days** of this Notice of Adverse Benefit Determination **[insert 10 calendar day date]**, you may continue to receive your same level of services while your Internal Appeal is pending. You have the right to request and receive benefits while your 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 request an Internal Appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action, whichever is later.

**If you want someone else to act for you:**

You can name a relative, friend, attorney, physician, or someone else to act as your representative. If you want someone else to act for you, call us at: [telephone number(s)] to learn how to name your representative. TTY users call [telephone number]. Both you and the individual you want to act for you must sign and date a statement confirming this is what you want. You will need to mail or fax this statement to us. Keep a copy for your records.

**Access to Documents:**

You and/or your authorized representative are entitled to reasonable access to a free copy of all documents relevant to your Appeal any time before or during the Appeal process. You must submit the request in writing.

**What happens Next:**

• If you ask for an Internal Appeal and are continually denied your request for coverage or payment of a service, you will be sent a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.

• The Notice of Appeal Denial will give you additional information about the State Fair Hearings process and how to file the request.

• If you do not receive a notice or decision about your Internal Appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System (MAHS).

**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]. You can also visit our website at [Agency Website URL].

• MMDHHS 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).

• [*If applicable, insert other state or local aging/disability waiver resources contact information.*]

[*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-*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)[*individuals/section-1557.]*](https://www.hhs.gov/civil-rights/for-individuals/section-1557)