[PLAN NAME/LOGO]

**Appeal Level:** **1**

**1 2 3 4**

**We Cannot Give You a Fast (or “Expedited”) Appeal**

**Name: Date of Notice:**

**Enrollee Number:**

**Appeal Number:**

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

Dear <Enrollee name>,

On <date appeal received, orally or in writing,> at <hour received> you, or someone acting for you, asked for a fast (or “expedited”) appeal for the following action: [*Insert* *a* *brief description of the Plan action (e.g. denial, reduction, 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 are not asking for more of a service than you are getting now, and 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 enrollee’s life, health or ability to regain maximum function or stay in their home or other residence. Also indicate that the enrollee 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 enrollee 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. We recommend keeping a copy of everything for your records.

**Grievance Contact Information:**

Phone <phone number>

Regular Mail <address>

Fax <fax number>

Delivery in Person <address>

Contacting your Care Manager <phone number>

**You will have a standard appeal**

Because we denied your request for a fast appeal, you will have a standard appeal. This is Level 1 of the appeal process. We will give you a written decision as fast as your condition requires but no later than 30 calendar days after we get your appeal (or 7 calendar days for Medicare Part B prescription drug appeals).

**We can take up to 14 calendar days longer to decide** if you ask for an extension, or if delaying the decision is best for you. If we take this extra time to decide, we will send you a written notice to explain why. We can’t take extra time to make a decision if your appeal is for a Medicare Part B prescription drug.

**Getting your case file and submitting evidence**

We will send you a free copy of the medical records and any other information we will use to make the appeal decision.

If you would like us to consider any evidence or testimony before we make our decision, you should submit it **as soon as possible**. You can submit evidence or testimony **1)** over the phone, **2)** by mail or fax, or **3)** by hand delivery at our drop-off location before your review. We recommend keeping a copy of everything for your records. Please submit evidence or testimony to:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

<Drop-off Address, if applicable>

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. You can choose anyone to represent you, like a family member, friend, doctor, or attorney.

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because he or she is a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, before that person is able to act for you, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf>. Send your letter or form to us by fax or mail. Keep a copy for your records. If you have any questions about naming your representative, such as what to say in your letter, call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the MAP program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[*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>   Website: <plan website>  Toll Free Phone: <phone number>  TTY users call: <TTY number>  <days and hours of operation>   * Independent Consumer Advocacy Network (ICAN)   Website: <http://icannys.org>  Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  Toll Free Phone: 1-844-614-8800  8:00am – 6:00pm, Monday – Sunday | * 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 |
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[*Plans must include all applicable disclaimers as required in the Medicare Communications and Marketing Guidance and any state-specific guidance provided by the New York State Department of Health*.]