**Important: Denial of service or treatment**We have denied a request for a service or treatment. Please call us right away at
###-###-### or TTY ### if you do not understand this letter. You can get this letter in large print, another language or any way that is best for you. You can ask for help from an interpreter. Help is free.

<<MCE Letterhead required
(include name, address
phone number; add
subcontractor if applicable)>>

<< Date of Notice>>

<<MEMBER NAME

ADDRESS

CITY, STATE ZIP>>

<<OHP Client ID, DOB>>

<<PCP/PCD/BHP/CLINIC/NOT YET ASSIGNED>>

**Denial of Service Request**(Also called Notice of Adverse Benefit Determination)

Dear <<Member name>>,

*For new PAs:* We were asked to approve a medical service for you. We could not approve it.

*For previously authorized services:* Your <<service(s)>> have/has been <<suspended/reduced/terminated>>.

This letter says why it was <<not approved/suspended/terminated/reduced>> and what you can do next.

|  |  |
| --- | --- |
| **Date decision is effective:** | <<Effective date>> |
| **Service <<denied, terminated reduced, suspended>>:** | <<Rx/Procedure/Service Name in plain language and procedure codes>>  |
| **Provider who requested it:** | <<Professional name>> |
| **Service requested on:** | <<Service request date>> |
| **Service is to help treat:** | <<Diagnosis codes and description of diagnosis in plain language. ~~Diagnoses submitted in request (~~~~when service is being denied as diagnosis is not funded or diagnosis and procedure do not pair on the Prioritized List~~)>> |
| **Reason for denial:**  | <<Reason for denial>>. <<Member specific info in plain language, related to criteria that was not met. This is why we were unable to approve the service. The Oregon Health Plan (OHP) does not pay all services and supplies.>> |
| **We based our decision on:** | <<List of all applicable OARs, Guideline Notes, HERC Clinical Guidance, medical policies or criteria, etc. OARs are listed with only the specific sections and subsections that apply to this member-specific decision.>> |

**<<We looked at other medical issues to pay for the service** When we looked at your records, we checked to see if you have a different medical issue that would let us pay for this. There are rules we have to meet in order to do this. We had a health care professional review your case to see if you met those rules. Unfortunately, you did not meet those rules.

If your provider thinks another medical issue will let us approve this, they can submit the request again.>>

**<<** We reached out to your provider for additional information to check and see if your medical service could be approved.

If your provider has additional information they can submit the request again >>

You can ask us to change our decision.
If you disagree with our decision, you have the right to ask us to change it. We will resolve your appeal as quickly as your health requires.

To support your appeal, you have the right to:

* Give information and testimony in person or in writing.
* Make legal and factual arguments in person or in writing.

You must do these things within appeal timeframes listed below.



**Appeals** -Call us at:
XXX-XXX-XXXX (TTY 711)
 **Hearings** - Call the state at:
800-273-0557 (TTY 711)

**Use the request form**
Scan the QR code to
get the form. Or go to <https://bit.ly/request2review>

**More about appeals and hearings**

|  |  |
| --- | --- |
| **How much time do I have?** | You have 60 days to ask for an appeal. We must get your request within 60 days of <<Date of Notice>>. |
| **How can I ask for an appeal?** | Contact us by phone, letter, or fax. * Call us at XXX-XXX-XXXX
* Use the Request to Review a Health Care Decision form. The form was sent with this letter. You can also get it at <https://bit.ly/request2review>
* You can also fax us at XXX-XXX-XXXX.
* You can mail your request to us at <<address/at the address at the top of the letter>>
 |
| **How long do you get to review my appeal?** | We get 16 calendar days to send you a reply. This is a normal appeal. If we need more time, we will call you and send you a letter within 2 days. We can delay our review up to 14 more days. This is also called an extension. |
| **What if I need a faster reply?** | You can ask for a fast appeal. This is also called an expedited appeal. Call us or fax the request form.Ask for a fast appeal if waiting for the regular appeal could put your life, health or ability to function in danger. ~~We have 3 days (72 hours) to reply if you get a fast appeal~~. If a fast appeal is approved we have 72 hours to call and notify you and your provider of your appeal results. We will notify you if we need more time. If a fast appeal is denied we will notify you within 2 days. When a fast appeal is denied or if we need more time, it moves to the normal appeal timeline. (See above)  |
| **What if I don’t agree with the delay or if you don’t meet the timelines above?** | If you do not agree with the delay, you can file a grievance or complaint. Call us at XXX-XXX-XXXX to file a complaint.If we don’t meet the timelines, you can ask the state for a review. This is called a hearing.  |
| **Who can ask for an appeal?** | You or someone with written permission to speak for you. That could be your doctor or an authorized representative.  |
| **How do I ask for a hearing?** | You have to ask for an appeal before you can ask for a hearing. If you do not agree with the appeal decision, ask the state to review it. The review is called a hearing. Choose one of these ways to ask for a hearing:* Submit a request online at <https://bit.ly/ohp-hearing-form>
* Use the request form that was sent with this letter or you can print the request form at <https://bit.ly/request2review>
* Call the state at 800-273-0557 (TTY 711)
 |
| **How much time do I have to ask for a hearing?** | You must ask for a hearing within 120 days of the date of the appeal decision letter. The letter is called a Notice of Appeal Resolution.  |
| **What if I need a faster hearing?** | You can ask for a fast hearing. This is also called an expedited hearing. Call the state at 800-273-0557 (TTY 711) or use the request form that was sent with this letter. Get the form at https://bit.ly/request2review |
| **When will I know if I can get a fast hearing?** | The state will call to follow up within 2 working days after getting your request. You will also get a letter if your request is denied.  |
| **Who can ask for a hearing?** | You or someone with written permission to speak for you. That could be your doctor or an authorized representative.  |

Other things you can do

* You can ask your doctor about other ways to treat your condition.
* You can ask us for the information used to make this decision.

These things will **not** give you more time to ask for an appeal or hearing, so you will need to do them right away.

In the middle of treatment?
If you have been getting this service and we stopped providing it, you, your provider or your authorized representative, with your written permission, can ask us to continue it.

* You need to ask for this within 10 days of the date of this letter or by the date this decision is effective, whichever is later. You can ask by phone, letter, or fax.
* You can also use the enclosed *Request to Review a Health Care Decision* form. Please answer “yes” to the question about continuing services in box 8 on page 4 of the form.

**Payment for this service**If you choose to still get this service, you may have to pay for it. If we change our decision during the appeal, or if the judge agrees with you at the hearing, you will not have to pay.

Get help

You can ask us for free copies of all paperwork used to make this decision.

If you need help or have questions, please call Customer Service at XXX-XXX-XXXX or TTY number, Monday to Friday, 8 a.m. - 5 p.m.

All members have a right to know about and use our programs and services. We give these kinds of free help:

* Sign language interpreters
* Spoken language interpreters
* Materials in other languages
* Braille, large print, audio, and any way that works better for you

For information on certified Health Care Interpreters call XXX-XXX-XXXX or TTY number.

CC: <<Professional Name>>

 <<Requesting Provider Name (if different from Professional Name)>>

<< Authorized Representative(if applicable)>>

Enclosures:

* Non-Discrimination Policy
* Request to review a health care decision (OHP 3302)
*

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| Language Access - English |
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| Language Access - Spanish |
| **Importante: Negación del servicio o tratamiento**Hemos rechazado una solicitud de servicio o tratamiento. Si no comprende esta carta, comuníquese con nosotros de inmediato llamando al XXX-XXX-XXXX. Puede recibir la carta en letra grande, otro idioma o bien de cualquier modo que sea más adecuado para usted. Puede solicitar la ayuda de un intérprete. La ayuda es gratuita.  |
| Language Access - Russian |
| **Важное примечание: Отказ в предоставлении обслуживания или лечения**Мы отклонили запрос на обслуживание или лечение. Если вам непонятна суть этого письма, срочно позвоните нам по телефону XXX-XXX-XXXX. Вы можете получить это письмо, напечатанное крупным шрифтом, на другом языке или в предпочитаемом вами формате. Вы можете сделать запрос на услуги устного переводчика. Помощь предоставляется бесплатно.  |
| Language Access - Vietnamese |
| **Quan trọng: Từ chối dịch vụ hoặc điều trị**Chúng tôi đã từ chối một yêu cầu dịch vụ hoặc điều trị. Vui lòng gọi ngay cho chúng tôi theo số XXX-XXX-XXXX nếu quý vị không hiểu nội dung trong thư này. Quý vị có thể nhận lá thư này theo dạng chữ in lớn, bằng một ngôn ngữ khác hoặc theo bất kỳ định dạng nào tốt nhất cho quý vị. Quý vị có thể nhờ thông dịch viên giúp đỡ. Chúng tôi sẽ trợ giúp quý vị miễn phí.  |
| Language Access - Arabic |
| **مهم: رفض تقديم خدمة أو علاج**لقد رفضنا طلبًا لتقديم خدمة أو علاج. يُرجى الاتصال بنا فورًا على الرقم XXX-XXXX-XXX إذا لم تفهم هذه الرسالة. يمكنك الحصول على هذه الرسالة في لغة أخرى، أو بخط كبير، أو بأي طريقة تفضلها. بإمكانك طلب المساعدة من مترجم شفوي. وتكون المساعدة مجانية. |
| Language Access - Simplified Chinese |
| **重要须知：拒绝提供服务或治疗**我们拒绝了要求提供服务或治疗的申请。若您不理解本函件的内容，请立即拨打 XXX-XXX-XXXX 联系我们。您可获取本函件的大字版、其他语言版或最适合您的版本。您可要求口语翻译人员提供帮助。您可获得免费帮助。 |
| Language Access - Traditional |
| **重要資訊：服務或治療的拒絕決定**我們已拒絕您的服務或治療申請。如果您不瞭解本信函的內容，請立即致電 XXX-XXX-XXXX 與我們聯絡。您可獲得本信函的大字版、其他語言版本或最適合您閱讀的任何格式。您可申請口譯員協助。協助為免費提供。 |
| Language Access - Somali |
| **Muhiim ah: Diidmada adeeg ama daaweyn**Waanu diidnay codsigii bixinta lacagta ee talagalay adeega ama daaweynta. Fadlan isla markiiba naga soo wac XXX-XXX-XXXX haddii aad fahmi waydo warqadan. Waxaad heli kartaa warqadan oo ku qoran far waaweyn, luqad kale ama hab kale oo adiga kuu fiican. Waxaad codsan kartaa caawimaad ka socota turjubaan. Caawimaadu waa mid lacag la’aan ah.  |