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

**Important: Results of your appeal request**You asked us to change our decision about a denial. This letter has our appeal decision. Please call us right away at XXX-XXX-XXXX 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. This help is free.

<< Date of Notice>>

MEMBER NAME

ADDRESS

CITY, STATE ZIP

<<OHP Client ID, DOB>>

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

**Results of your request to change our decision**(Also called Notice of Appeal Resolution)

Dear <<Member name>>,

On <<request date>>, we got your appeal request to change the decision we made. We looked at your records again. We also looked at what you told us in your appeal request. We requested any new records that were sent about you and this service. This letter explains our decision and what you can do next.

|  |  |
| --- | --- |
| **Appeal (decision) results:** | <<Decision in plain language. Denied, terminated reduced, suspended. We have decided to overturn (reverse) our denial decision. / We have decided to uphold (not change) our denial.>> |
| **Date decision is effective:** | <<Effective date>> |
| **Service that was <<denied, approved, partially approved>>:** | <<Plain language description of denied service and procedure codes>> |
| **Service was to help treat:** | <<Diagnosis in plain language, diagnosis codes>> |
| **Provider who requested it:** | <<Provider name>> |
| **Reason for appeal results:** | <<Member-specific reasons why coverage criteria was not fully met>>. |
| **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.>> |

A copy of this letter has been sent to your provider.

When we looked at your records, we checked to see if you have a different medical issue that would let us cover 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.

<<**Did you get a bill?**If you get a bill for this service, call our Customer Service at <<XXX-XXX-XXXX / the number listed below>>. Do not pay the bill until you talk to us. We will see why you got a bill.

Providers should not bill you if a service is covered. If a service is not covered and you signed a valid Oregon Health Plan Agreement to Pay for Health Services form, you have to pay for it. You can see the waiver form at <https://bit.ly/OHPwaiver>. If you do not know if you signed a waiver form, ask your provider’s office.>>

You can ask for a hearing to change our decision   
If you disagree with our decision, you have the right to ask for a hearing with a judge to change it.

The state will call you to get more information. They will let you know if you can have a hearing / when you can have it.

**Wait for the reply**

This is called a hearing. You have 120 days from this letter’s date. Call 800-273-0557 (TTY 711) or use the form to ask for a hearing.

**Ask the state to review our decision**

Ask for fast hearing when you call or mark it on the form. The state will tell you in 2 working days if you can have a fast hearing.

**Need a faster hearing?**

Don’t agree with our decision? Follow these steps:

**1**

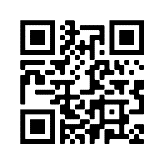
**2**

**3**



**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 hearings

|  |  |
| --- | --- |
| **How do I 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>  Fast hearings are for services that you have not had yet. Services already provided will not get a fast hearing. |
| **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.

In the middle of treatment?  
If you have been getting this service and we have 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 the judge agrees with you at the hearing, you will not have to pay.

Get help or copies of paperwork  
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
* Spoken language interpreters
* Materials in other languages
* Braille, large print, audio, and any way that works better for you

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

For information on certified Health Care Interpreters call <<XXX-XXX-XXXX>>.

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)

|  |
| --- |
| English |
| You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call #CustomerService# or TTY #TTY#. We accept relay calls. |
| Spanish |
| Puede obtener este documento en otros idiomas, en letra grande, braille o en un formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente #CustomerService# o TTY #TTY#. Aceptamos todas las llamadas de retransmisión. |
| Russian |
| Вы можете получить это письмо на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги переводчика. Эта помощь предоставляется бесплатно. Звоните по тел. #CustomerService# или TTY #TTY#. Мы принимаем звонки по линии трансляционной связи. |
| Vietnamese |
| Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi #CustomerService # hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) #TTY#. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp. |
| Arabic |
| يمكنكم الحصول على هذا الخطاب بلغات أخرى، أو مطبوعة بخط كبير، أو مطبوعة على طريقة برايل أو حسب الصيغة المفضّلة لديكم. كما يمكنكم طلب مترجم شفهي. إن هذه المساعدة مجانية. اتصلو على #CustomerService# أو المبرقة الكاتبة #TTY#. نستقبل المكالمات المحولة. |
| Somali |
| Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la’aan. Wac #CustomerService# ama TTY #TTY#. Waa aqbalnaa wicitaanada gudbinta. |
| Simplified Chinese |
| 您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电#客户服务部# 或TTY #TTY#。我们会接听所有的转接来电。 |
| Traditional Chinese |
| 您可獲得本信函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電 #CustomerService# 或聽障專線 #TTY#。我們接受所有傳譯電話。 |