**THIS IS NOT A BILL**

**Important: Denial of payment for service**This is not a bill. We have denied a request from your provider to pay for a service or treatment. Please call us right away at ###-###-### 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; can add   
subcontractor)>>

<< NOTICE DATE>>

<<MEMBER NAME

ADDRESS

CITY, STATE ZIP>>

<<OHP Client ID, DOB, PCP/PCD/BHP>>

**Reason for Payment Denial**(Also called Notice of Adverse Benefit Determination)

Dear <<Member name>>,

This is not a bill. You do not need to do anything. We have to send this to you so you have the information.   
  
We were asked to pay for a service you received. We are not able to pay for it. This letter says why the request was not approved and what you can do next. This decision is effective <<effective date>>.

|  |  |
| --- | --- |
| **Service payment was  requested for:** | <<Rx/Procedure/Service Name in plain language>> |
| **Date of service:** | <<date of service>> |
| **Provider or facility name:** | <<Name of requesting/ performing/ billing provider/facility>> |
| **Service was to help treat:** | <<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 payment denial:** | <<Reason for denial>>. <<Member specific info in plain language, related to criteria that was not met. This is why we were unable to pay for the service. The Oregon Health Plan (OHP) does not cover all services and supplies.>> |
| **Claim number:** | <<claim number, date if different than service date>> |
| **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**  
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.

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

**<<****We did not look at other medical issues**  
You may have other medical issues that would let us cover this service. There are rules we have to meet in order to do this. Your provider can ask us to review your case to see if you meet those rules.

You can ask your provider to submit the request again.>>

**Did you get a bill? Call us right away.**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 Financial Waiver, 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.

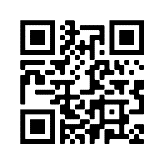
You can ask us to change our decision.   
If you disagree with our decision, you have the right to ask us to change it.





**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?** | Call us at XXX-XXX-XXXX or 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 the form to XXX-XXX-XXXX. |
| **How long do you get to review my appeal?** | We get 16 calendar days to send you a reply. If we need more time, we will send you a letter. We have up to 14 more days. |
| **What if you don’t meet the timeline?** | If we take longer than 30 days to reply, you can ask the state for a review. This is called a hearing. |
| **What if I need a faster reply?** | Fast appeals are for services you did not get yet. If you already got the service, a fast appeal request will not be approved. |
| **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.  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> |
| **How much time do I have to ask for a hearing?** | You have 120 days after you get the appeal decision letter. 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 fast hearing?** | Fast hearings are for services you did not get yet. If you already got the service, a fast hearing request will not be approved. |
| **Who can ask for a hearing?** | You or someone with permission to speak for you. That could be your doctor or an authorized representative. They don’t need permission in writing. |

Other things you can do

You can do other things besides requesting an appeal or hearing. See page 2 of the enclosed *Request to Review a Health Care Decision* form for more information. You can also get the form at <https://bit.ly/request2review>.

In the middle of treatment?  
If you are in the middle of this treatment, you can ask us to continue it. If you choose to get this service in the future, 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.

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. Use the contact information <<below>>.
* Answer “yes” to the question about continuing services on box 8 on page 4 on the *Request to Review a Health Care Decision* 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

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
* Copies of all paperwork used to make this decision

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

CC: <<Requesting Provider Name>>

Enclosures:

* Non-Discrimination Policy
* Request to review a health care decision (OHP 3302)
* COVID-19 hearing extension