TEMPLATE G(3)

NOTICE FOR PAYMENT DENIAL BECAUSE THE SERVICE(S)/ITEMS(S) WAS NOT A COVERED BENEFIT FOR THE PARTICIPANT

THIS IS NOT A BILL

[Date Notice Mailed (date decision is made to deny payment)]

Participant Name
Address
City, State Zip

Participant ID: *********

Dear **[Participant Name]**:

[CHC-MCO Name] has reviewed the request from **[provider's name]** to be paid for **[identify specific service/item]** you received on **[date**]. Your provider's request for payment has been denied. The service or item you received is not a covered benefit because:

___ It is not covered under the Medical Assistance Program; **OR**

___ It is not part of your benefit package; **OR**

___ **[Provider name]** is not in **[CHC-MCO Name]**'s provider network and did not ask [**[CHC-MCO Name]** for approval to provide the service or item to you.

[PROVIDER'S NAME] MAY BILL YOU FOR THIS SERVICE or ITEM ONLY IF [PROVIDER'S NAME] TOLD YOU THAT THE SERVICE or ITEM WAS NOT COVERED FOR YOU BEFORE YOU GOT THE SERVICE or ITEM.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A COMPLAINT with **[CHC-MCO Name] within 60 days from the date you get this notice**. **[CHC-MCO Name]** will tell you its decision about your Complaint within **[30**, **unless the CHC-MCO will be using a shorter time frame to provide notice of 1st level Complaint decisions]** days from when **[CHC-MCO Name]** gets your Complaint.

To file a Complaint:

By Phone: Call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**;

By Fax: Fax the "Complaint Request Form" or a letter to **[CHC-MCO FAX #]**; or

By Mail: Mail the "Complaint Request Form" or a letter to the following address:

[CHC-MCO ADDRESS
FOR FILING COMPLAINT/GRIEVANCE]

If you file a Complaint, you may ask **[CHC-MCO Name]** to see any information used to make this decision, at no cost to you. To ask for information used to make this decision:

- Call **[CHC-MCO Name]** at **[CHC-MCO Phone # &Toll Free TTY/PA RELAY]** or
- Check Box 2 on the "Complaint Request Form" or
- Write a letter.

Send the form or letter to the following:

Fax number: **[CHC-MCO FAX #]**

Mailing address:
[ADDRESS FOR REQUESTING INFORMATION USED TO MAKE A DECISION]

If you need help filing a Complaint, you can call **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]**.

To ask for free legal help with filing a Complaint, you can call:

- Pennsylvania Health Law Project at 1-800-274-3258 (www.phlp.org)
- Pennsylvania Legal Aid Network at 1-800-322-7572 (www.palegalaid.net)

Sincerely,

[CHC-MCO Name]

cc: [**Provider]**

COMPLAINT REQUEST FORM

Participant: _____ **Participant ID #:** _____

Phone number: _____

Address:_____

Date on the [CHC-MCO] Notice: _____

1. **Check how you would like to be present at the review of your Complaint:**

   ☐ **BY TELEPHONE** (You will be sent the date and time of the review at least 10 days before the Complaint review. You will be called at the phone number you provided above.)
   ☐ **BY VIDEOCONFERENCE [CHC-MCO to include only if available]** (You will be sent the date and time of the review at least 10 days before the Complaint review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review at least 10 days before the Complaint review.)
   ☐ **NOT BE PRESENT** (You can change your mind at any time. You will be sent the date and time of the Complaint review. The decision on your Complaint will not be affected if you are not present.)

2. **Would you like a copy of the information [CHC-MCO Name] used to make the decision you are filing a Complaint about? Yes ☐ No ☐**
3. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____
   The interpreter will be free.
4. **Why do you disagree with [CHC-MCO Name]'s decision?** (Attach more pages if needed. You will be able to fully explain why you disagree during the Complaint review.)

   _____

   _____

   _____

   _____

5. **If someone will be helping you with your Complaint, please provide his or her information:** (If you do not yet have anyone helping you, just leave this blank and you can let **[CHC-MCO Name]** know later if someone will be helping you.)

   Representative's name and phone number: _____

   Representative's address: _____

   Relation to Participant: _____

Participant's Signature: _____**Date:**_____

Send to: **[CHC-MCO Complaint address] OR**

[CHC-MCO Complaint fax #]

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE