TEMPLATE G(4)

NOTICE FOR DENIAL OF PAYMENT AFTER A SERVICE(S) HAS BEEN DELIVERED BECAUSE THE EMERGENCY ROOM SERVICE(S) WAS NOT MEDICALLY NECESSARY

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 you received was not Medically Necessary because: **[Explain at a 6th grade reading level in detail every reason for denial. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based, in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

[PROVIDER'S NAME] MAY NOT BILL YOU FOR THIS SERVICE. YOU CAN SHOW THIS NOTICE TO [PROVIDER'S NAME] IF [PROVIDER'S NAME] SENDS YOU A BILL.

Sincerely,

[CHC-MCO Name]

cc: **[Provider]**

[NONDISCRIMINATION NOTICE/LEP/LANGUAGE ACCESS INFORMATION HERE]