TEMPLATE G(8)

FIRST LEVEL COMPLAINT DECISION NOTICE

[CHC-MCO: Use if the Complaint is NOT about the following: a denial because the service or item is not a Covered Service; the failure of the CHC-MCO to provide a service or item in a timely manner, as defined by the Department; the failure of the CHC-MCO to decide a Complaint or Grievance within the specified time frames; a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item was provided without authorization by a provider not enrolled in the Medical Assistance Program; a denial of payment by the CHC-MCO after the service or item has been delivered because the service or item provided is not a Covered Service for the Participant; or a denial of a Participant's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Participant financial liabilities.]

[Date Notice Mailed (date of the Complaint decision)]

Participant Name
Address
City, State Zip

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

Subject: Decision About Your First Level Complaint

Dear **[Participant Name]**:

[CHC-MCO Name] has reviewed your Complaint about **[issue]**, received on **[date]**.

Based on a review of all information provided, the First Level Complaint review committee has decided that **[state decision in detail at a 6th-grade reading level]**.

The reasons for this decision are: **[Explain at a 6th grade reading level in detail every reason for decision. 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.]**

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY FILE A SECOND LEVEL COMPLAINT with **[CHC-MCO Name] within 45 days from the date you get this notice**. **[CHC-MCO Name]** will tell you the decision on your Complaint within **[45, unless the CHC-MCO will be using a shorter timeframe to provide notice of 2nd level Complaint decisions]** days from when **[CHC-MCO Name]** receives your Second Level Complaint.

To file a Second Level Complaint:

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

By Fax: Fax the "Complain 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]

To ask for an early decision

If your doctor or dentist believes that waiting **[45** days**, unless the CHC-MCO will be using a shorter time frame]** days to get a decision could harm your health, you may ask that your Complaint be decided more quickly. For your Complaint to be decided more quickly:

You must ask for an early decision by calling **[CHC-MCO Name]** at **[Phone# & Toll-free TTY/PA RELAY #]** or faxing a letter or the "Complaint Request Form" to **[CHC-MCO FAX #].**

Your doctor or dentist should fax a signed letter to **[CHC-MCO FAX #]** within 72 hours of your request for an early decision that explains why **[CHC-MCO Name]** taking **[45** days**, unless the CHC-MCO will be using a shorter time frame]** days to tell you the decision about your Complaint could harm your health.

[CHC-MCO Name] will tell you the decision within 48 hours from when **[CHC-MCO Name]** gets your doctor's or dentist's letter, or within 72 hours from when **[CHC-MCO Name]** gets your request for an early decision, whichever is sooner, unless you ask **[CHC-MCO Name]** to take more time to decide your Complaint. You can ask **[CHC-MCO Name]** to take up to 14 more days to decide your Complaint.

Ask for Information Used to Make This Decision

You or your representative may ask **[CHC-MCO Name]** to see any information used to decide your First Level Complaint, at no cost to you.

To ask for the information used to decide your First Level Complaint:

- Call **[CHC-MCO Name]** at **[CHC-MCO Phone # &Toll Free TTY/PA RELAY]** or
- Check "yes" at number 3 of 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]

Help with Your Complaint

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

To ask for free legal help with your Second Level Complaint or with filing your Second Level Complaint, you can contact:

- 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: **[Participant representative, if designated]**
[Service Provider, if applicable]
[Prescribing Provider, if applicable]

COMPLAINT REQUEST FORM

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

Phone number: _____

Address_____

Date on the [CHC-MCO] Complaint 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 15 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 15 days before the Complaint review.)
   ☐ **IN PERSON** (You will be sent the date, time, and location of the review at least 15 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. **Will waiting the normal time frame for a decision on your Second Level Complaint harm your health? Yes ☐ No ☐**
   (See the instructions in the Complaint notice about how to ask for an early decision.)
3. **Would you like a copy of the information [CHC-MCO Name] used to make the decision you are filing a Complaint about? Yes ☐ No ☐**
4. **Do you need an interpreter? Yes ☐ No ☐ Language?** _____
   The interpreter will be free.
5. **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.)

   _____

   _____

   _____

   _____

6. **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]