Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

Notice of Denial of Medical Coverage

|  |
| --- |
| **Date of Notice:** <<PRINTDATE>> |
| **Member Name:** <<FIRSTNAME>> <<LASTNAME>> |
| **Member Number/ID:** <<MEMBERn>> |
|  |
|  |
|  |

|  |
| --- |
| **Your request was <partially approved, denied>**  We’ve <denied, partially approved, stopped, reduced, suspended> the < medical services/items, Part B drug> listed below requested by you or your <doctor, provider>:  {*Clearly and specifically list the denied medical services/items or Part B drug.*} |

|  |
| --- |
| **Why did we deny your request?**  We <denied, partially approved, stopped, reduced, suspended>the < medical services/items, Part B drug> listed above because:  {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision.} |

You should share a copy of this decision with your <doctor, provider> so you and your <doctor, provider> can discuss next steps. If your <doctor, provider> requested coverage on your behalf, we have sent a copy of this decision to your <doctor, provider>.

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**You have the right to appeal** **our decision**

You have the right to ask Aspirus Health Plan to review our decision by asking us for an appeal.

**Plan Appeal:**

Ask Aspirus Health Plan for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an appeal with Aspirus Health Plan for information on how to ask for a plan level appeal.

**If you want someone else to act for you**

You can name a relative, friend, attorney, provider, or someone else to act as your representative. If you want someone else to act for you, call us at: 715-631-7411 or 855-931-4850 toll free, to learn how to name your representative. TTY users call 715-631-7413 or 855-931-4852 toll free. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

**Important Information About Your Appeal Rights**

***There are 2 kinds of appeals with Aspirus Health Plan***

**Standard Appeal –** We’ll give you a written decision on a standard appeal within 30 **days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a service you’ve already received, we’ll give you a written decision within **60 days**.

**Fast Appeal –** We’ll give you a decision on a fast appeal within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your provider believe your health could be seriously harmed by waiting up to **30 days** for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a medical service/item you’ve already received.

**We’ll automatically give you a fast appeal if a provider asks for one for you or if your provider supports your request.** If you ask for a fast appeal without support from a provider, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within **30 days**.

**How to ask for an appeal with Aspirus Health Plan**

**Step 1:** You, your representative, or your provider must ask us for an appeal. Your request must include:

* Your name
* Address
* Member number
* Reasons for appealing
* Whether you want a Standard or Fast Appeal (for a Fast Appeal, explain why you need one).
* Any evidence you want us to review, such as medical records, providers’ letters (such as a provider’s supporting statement if you request a fast appeal), or other information that explains why you need the medical service/item. Call your provider if you need this information.

If you’re asking for an appeal and missed the deadline, you may ask for an extension and should include your reason for being late.

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal.

|  |  |  |
| --- | --- | --- |
| **For a Standard Appeal:** | MailingAddress: |  |
|  |  | Attn: Appeals and Grievances  Aspirus Health Plan |
|  |  | P.O. Box 51 |
|  |  | Minneapolis, MN 55440-0052] |
|  |  |  |
|  | Phone: | 715-631-7440 or 855 -931-4858 toll free |
| TTY Users Call: | | 715-631-7413 or 855- 931-4852 toll free |
|  | Fax: | 715-631-7439 or 855- 931-4857 toll free |
|  |  |  |
|  | | |
| **For a Fast Appeal:** | Phone: | 715-631-7440 or 855 -931-4858 toll free |
| TTY Users Call:  Fax: | | 715-631-7413 or 855- 931-4852 toll free  715-631-7439 or 855- 931-4857 toll free |

**What happens next?**

If you ask for an appeal and we continue to deny your request for a medical/service, we’ll automatically send your case to an independent reviewer. **If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.**

**Get help & more information**

* Aspirus Health Plan Toll Free: 715-631-7411 TTY users call: 1-855-931-4852 toll free 8 am – 8 pm, seven days a week or Aspirushealthplan.com
* 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call: 1-877-486-2048
* Medicare Rights Center: 1-888-HMO-9050
* Elder Care Locator: 1-800-677-1116 or www.eldercare.acl.gov to find help in your community.

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