

<<IPA>>

<<Date>>

<<Member Name>>  
<<Address Line 1>> <<Address Line 2>>  
<<City>>, <<ST>> <<Zip>>

Member's Name: <Member Name>  
Member ID #: <Member ID>

Doctor's Name: < Requesting Provider>  
Requested Service: <Service Category>  
Date of Request: <MM/DD/YYYY>

Health Plan Name: IEHP DualChoice (HMO D-SNP)  
Health Plan Phone Number: **1-877-273-IEHP (4347)**, TTY users should call **1-800-718-4347**  
Health Plan Hours of Operation: 8am-8pm (PST), 7 days a week, including holidays

Attending Doctor's Name: <Doctor>

Dear <Member>:

We hope this letter finds you well. We are writing about you or your Doctor's request for a [expedited 72-hour (delete if this does not apply)] coverage decision about the service noted above. <<IPA>> needs to extend our review past the <72-hour or 14 calendar day> timeframe.

We need to extend your request by <insert #> calendar days because:

OPTION 1: You or your Doctor asked to extend the timeframe so that more information could be gathered. [**<<IPA>> or its delegated Doctor must explain how the need for this additional information is reasonable and necessary and in the interest of the Member.**]

OPTION 2: We believe more information is needed to help our review of your or your Doctor's request. [**<<IPA>> or its delegated Doctor must explain how the need for this additional information is reasonable and necessary, and in the interest of the Member. For example, the receipt of additional medical evidence from non-contracted Doctors or additional tests may change a Medicare Advantage Organization's (MAO's) or Doctor /Medical Group's decision to deny.**]

We will not extend your [expedited 72-hour (delete if this does not apply)] request by more than 14 calendar days from the date of the expedited or standard request.

You may file an expedited oral or written grievance (complaint) with IEHP DualChoice if you disagree with our action to delay its decision. The grievance process allows a Member to file a complaint with IEHP DualChoice about issues other than denied claims or services. IEHP DualChoice must respond to an expedited grievance within 24-hours of receipt. To file an expedited grievance, you or your authorized representative should telephone, mail or fax your grievance to:

**IEHP DualChoice**  
**P.O. Box 1800**  
**Rancho Cucamonga, CA 91729-1800**  
**Toll Free: 1-877-273-IEHP (4347) or for TTY Users 1-800-718-4347**  
**Fax: 1-909-890-5748**

We will continue to make every effort to obtain the needed information so that we can complete the review of this matter. Please direct any further questions or information to <<IPA>> Member Services at <<Number>>, <<Hours/Days>>. TTY users should call <<Number>>.

Thank you for being a valued Member of <<IPA>>.

To your health,

<<IPA>>

cc: Doctor if Doctor is requested.