

<IPA>

<<Date>>

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

## Coverage Decision Letter

[IMPORTANT: For help with this notice, call <IPA Name> at  
<insert IPA customer service phone #> (TTY: <TTY number>) **OR**  
**MMCD Office of the Ombudsman at**  
**1-888-452-8609 (TTY: 1-800-719-5798).]**

Member Health Plan ID: <<Member ID>>

Service/item this letter is about:

Reference Number:

IEHP DualChoice (HMO D-SNP) is called “our plan” or “we” in this letter. We are a health plan that contracts with Medicare and Medi-Cal to provide coverage for both programs. Our plan coordinates your Medicare and Medi-Cal services and your doctors, hospitals, pharmacies, and other health care providers.

**Our plan <denied or partially denied or reduced or stopped or suspended> the service listed below:**

*[Insert description of service, including the amount, duration, and scope, of what the enrollee requested (e.g., physical therapy visits 2 times per week for 1 year), and the outcome, denied, partially denied, reduced, stopped, suspended, or changed, and include the doctor or provider’s name if a particular doctor or provider requested the service or item. If a service or item request is partially denied, reduced, or changed, include specifically what was requested and what is approved (e.g., We are approving acupuncture services for 3 months instead of a full year, or We are approving moving a toilet to the south wall instead of the east wall of the bathroom, or We previously*

*approved 18 acupuncture visits per year but are now reducing the visits to only allow 10.)]*

[Insert if this is a post-service case for which there is no member liability: **Please note, you will not be billed or owe any money for this service.**]

Our plan made this decision because *[Provide a specific denial reason and a concise explanation of why the service was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision in plain language. The plain language explanation of the decision should include: (1) relevant context for the decision (e.g., if the service was approved for the enrollee in the past, the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now); (2) coverage information considered including Medicare and Medi-Cal coverage benefits; and, (3) if applicable, information on how or why the requested service or item is not supported by the enrollee's needs – see instructions for more information].*

*[Insert if denial will result in a stoppage, suspension, or reduction of a service or item the individual has already been receiving: **Our plan will <reduce or stop or suspend> your service on <effective date>**. See the “How to keep getting your service during your appeal” section later in this letter for information about continuing to receive your service during your appeal.]*

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

You can appeal our plan's decision. Share this letter with your health care provider and ask about next steps. If you appeal and our plan changes its decision, we may pay for the service.

You can also call 1-877-273-IEHP (4347) (TTY: 1-800-718-4347) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your health care provider to help you decide if you should appeal.

**You must appeal by** *[Insert specific appeal filing deadline date in month, date, year format – 60 calendar days from date of letter. Insert deadline date in bold text]*. Our plan may give you more time if you have a good reason.

## **There are two kinds of appeals**

**Our plan has two kinds of appeals – standard appeals and fast appeals.**

1. If you ask for a **standard appeal**, our plan will send you a written decision within **7 calendar days after we get your appeal**.
2. If you ask for a **fast appeal**, our plan will give you a decision within **72 hours after we get your appeal**. You can ask for a fast appeal if you or your health care provider believe your health could be **seriously harmed** by waiting up to **7 calendar days** for a decision.

Our plan **automatically** will give you a fast appeal if your **health care provider asks for one for you** or if your **health care provider supports your request**. If you ask for a fast appeal without support from a health care provider, our plan will decide if you can get a fast appeal. If our plan doesn't approve a fast appeal, we'll give you a decision on your appeal within **7 calendar days**.

For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.

## **How to appeal**

You, someone you have named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or health care provider can appeal. You can contact our plan to appeal in one of these ways:

- **Phone:** Call IEHP DualChoice Member Services at 1-877-273-IEHP (4347) (TTY: 1-800-718-4347)
- **Fax:** Send a fax to 909-890-5748
- **Mail:** Mail it to IEHP DualChoice Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91730-5987
- **In person:** Deliver it to 10801 6<sup>th</sup> Street, Rancho Cucamonga, CA 91730-5987

If you appeal in writing, keep a copy. If you call, we'll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

- Your name
- Your address or an address where we should send information about your appeal (if you don't have a current address, you can still appeal)
- Your member number with our plan
- The reason(s) you're appealing our decision
- If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
- Anything you want our plan to look at that shows why you need the service. For example, you can send us:
  - Medical records from your health care provider,

- Letters from your health care provider (such as a statement from your health care provider that says why you need a fast appeal), or
- Other information that says why you need the service

To get more information on how to appeal, call Member Services at 1-877-273-IEHP (4347) (TTY: 1-800-718-4347). You can also find more information in our plan's Evidence of Coverage. An up-to-date copy of the Evidence of Coverage is always available on our website at [www.iehp.org](http://www.iehp.org) or by calling our plan.

## **How to keep getting your service during your appeal**

If you're already getting the service listed on the first page of this letter, you can ask to keep getting it during your appeal.

- **You must appeal and ask our plan to continue getting your service within 10 calendar days from the date of this notice.**
- See the "How to appeal" section earlier in this letter for information about how to contact our plan.
- If you ask our plan to continue your service, your service will stay the same during your appeal.
- If your health care provider is filing the appeal for you and you want to keep getting your service, then your health care provider must include your written consent.

## **What happens next**

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies the service listed on the first page of this Coverage Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask The California Department of Social Services for a State Hearing.

## **What to do if you need help with your appeal**

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your "representative" by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

- Call our plan at 1-877-273-IEHP (4347) (TTY: 1-800-718-4347) to learn how to name that person as your representative. Or, you can visit [Medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me](https://www.medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me).

- You and your representative must sign and date a statement that says this is what you want.
- Mail or fax the signed statement to us at:

IEHP DualChoice Grievance Department, P.O. Box 1800, Rancho Cucamonga, CA 91730

Fax: 909-890-5748

- Keep a copy.

## Get help and more information

- **IEHP DualChoice Member Services:** Call 1-877-273-IEHP (4347) (TTY: 1-800-718-4347), 8am-8pm (PST), 7 days a week, including holidays. You can also visit [www.iehp.org](http://www.iehp.org).
- **Ombudsman Office of the California Department of Health Care Services (DHCS):** Call 1-888-452-8609 (1-800-719-5798). The Ombudsman Office can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren't connected with our plan or with any insurance company or health plan. Their services are free.
- **California Health Insurance Counseling and Advocacy Program (HICAP):** Call 1-800-434-0222 (TTY: 711). HICAP counselors can help you with Medicare issues, including how to appeal. HICAP isn't connected with any insurance company or health plan. Their services are free.
- **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit [Medicare.gov](http://Medicare.gov).
- **Medi-Cal:** Call 1-800-541-5555 (TTY: 711).
- **Medicare Rights Center:** Call 1-800-333-4114, or visit [www.medicarerights.org](http://www.medicarerights.org).
- **Eldercare Locator:** Call 1-800-677-1116, or visit [www.eldercare.acl.gov](http://www.eldercare.acl.gov) to find help in your community.

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You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-273-IEHP (4347) (TTY: 1-800-718-4347), 8am-8pm (PST), 7 days a week, including holidays. The call is free.

You have the right to get Medicare information in an accessible format, like large print, Braille, or audio. You also have the right to file a complaint if you feel you've been discriminated against. Visit [Medicare.gov/about-us/accessibility-nondiscrimination-notice](http://Medicare.gov/about-us/accessibility-nondiscrimination-notice), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

*IEHP DualChoice (HMO D-SNP) is an HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.*