[Insert the sending entity's logo and contact information]

<Date>

<Name of Beneficiary or Representative>
<Address>

Member's Name: <Member Name>

Physician Name: < Requesting Provider>

Member ID #: <Member ID>

Requested Service: <Service Category>

Health Plan Name: IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)

Health Plan Phone #: 1-877-273-IEHP(4347)

Health Plan Hours of Operation: 8am – 8pm (PST),

7 days a week, including holidays

Date of Standard Request: <MM/DD/YYYY>

Date of Expedited Request: <MM/DD/YYYY>

Attending Physician's Name: <Physician>

Time of Expedited Request <HH:MM>

Dear <Member>:

This notice is in response to you or your physician's request for an [expedited seventy-two (72) hour-delete if not applicable] coverage decision regarding the services noted above. <IEHP DualChoice or IPA> needs to extend our review past the <72-hour or 14 calendar day> timeframe.

In the case of your request, a <insert #> calendar day extension is required because:

OPTION 1: You or your physician requested an extension so that additional information could be collected. [IEHP DualChoice or its delegated physician/ must explain how the need for this additional information is reasonable and necessary and in the interest of the member.]

OPTION 2: We believe additional information requested will help our review of your or your physician's request. [IEHP DualChoice or its delegated physician/ 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 physicians or additional tests may change a Medicare Advantage Organization's (MAO's) or physician /Medical Group's decision to deny.]

[Insert the sending entity's logo and contact information]

We may not extend your [expedited seventy-two (72) hour-delete if not applicable] request by more than fourteen (14) additional calendar days from the date of the expedited or standard request.

During this extension, [insert description of what the beneficiary must do in lay terms]

You may file an expedited oral or written grievance (complaint) with IEHP DualChoice if you disagree with our decision to delay its determination. 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 twenty-four (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 necessary information as soon as possible in order to complete the [expedited, delete if not applicable] review of this matter. Please direct any further questions or information to IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347.

Sincerely,

<IEHP DualChoice/Medical Group/IPA>

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

cc: Physician, if Physician requested

DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IEHP Member Services at 1-877-273-4347 (TTY: 1-800-718-4347).

If you believe that IEHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email:CivilRights@iehp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
Tel. 1-800-368-1019, (TDD: 800-537-7697). Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

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Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:

- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
  - Intérpretes calificados
  - Información escrita en otros idiomas

Si necesita recibir estos servicios, comuníquese con Servicios para Miembros de IEHP al 1-877-273-4347 (TTY: 1-800-718-4347).

Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email:CivilRights@iehp.org

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.

DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

> U.S. Department of Health and Human Services,
> 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
> Tel. 1-800-368-1019, (TDD: 800-537-7697). Puede obtener los formularios de queja en el sitio web: http://www.hhs.gov/ocr/office/file/index.html

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-877-273-4347(TTY: 1-800-718-4347).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-273-4347(TTY: 1-800-718-4347).

العربية (ARABIC)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-877-273-4347 (رقم هاتف الصم والبكم: 1-800-718-4347).

Հայերեն (ARMENIAN)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-273-4347(TTY (հեռատիպ)՝ 1-800-718-4347):

繁體中文 (CHINESE)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-273-4347 (TTY：1-800-718-4347)。

فارسی (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-273-4347 (TTY: 1-800-718-4347) تماس بگیرید.

हिंदी (HINDI)
ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-273-4347(TTY: 1-800-718-4347) पर कॉल करें।

LANGUAGE ASSISTANCE

Hmoob (HMONG)
LUS CEEV: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus hmoob pub dawb rau koj. Hu rau 1-877-273-4347(TTY: 1-800-718-4347).

日本語 (JAPANESE)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
1-877-273-4347（TTY:1-800-718-4347）まで、お電話にてご連絡ください。

ខ្មែរ (KHMER)
ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-877-273-4347 (TTY: 1-800-718-4347)។

한국어 (KOREAN)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-877-273-4347 (TTY: 1-800-718-4347)번으로 전화해 주십시오.

ພາສາລາວ (LAO)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-877-273-4347(TTY: 1-800-718-4347).

ਪੰਜਾਬੀ (PUNJABI)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ **(Punjabi)** ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫ਼ਤ ਉਪਲਬਧ ਹਨ। ਕਿਰਪਾ ਕਰਕੇ 1-877-273-4347(TTY: 1-800-718-4347) 'ਤੇ ਕਾੱਲ ਕਰੋ।

Русский (RUSSIAN)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-273-4347(елетайп: 1-800-718-4347).

TAGALOG (TAGALOG – FILIPINO)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-273-4347(TTY: 1-800-718-4347).

ภาษาไทย (THAI)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-273-4347 (TTY: 1-800-718-4347).

Tiếng Việt (VIETNAMESE)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-273-4347(TTY: 1-800-718-4347).