IPA LOGO

Notice of Dismissal of Coverage Request

Date:

Enrollee's Name: **Enrollee ID Number:**
Reference Number:
(Insert non-contract provider name, if applicable):

Plan Name: IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan)
Phone: <Phone number> Fax: <Fax number>

We dismissed the coverage request you filed on *(insert date)*.

We can't process your request because: *(explain the specific reason for dismissal and what is missing from the request -- e.g., person making the request is not a proper party and there isn't an appointment of representation (AOR) form. 42 CFR §§ 422.568(g), 422.631(e) and 423.568(i) and for additional guidance, see the Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance for when it may be appropriate to dismiss a coverage request.)*

Do You Have Questions?

If you have questions about this notice, please contact IEHP DualChoice/IPA at:

Toll Free Phone: <Phone number> Days & hours of operation: <Hours (PST), # days a week, including holidays>

TTY Users Phone: <TTY number> Days & hours of operation: <Hours (PST), # days a week, including holidays>

If you disagree with our decision to dismiss your coverage request, you have two options:

1. If you think we have incorrectly dismissed your coverage request, for example, you believe you are a proper party, you may request that we review our dismissal. Your appeal must be received by us at 10801 6th Street, Rancho Cucamonga, CA 91730 or by fax at (909) 890-5748 within **60 calendar days** of the date of this dismissal notice. Include a copy of this ***Notice of Dismissal of Coverage Request***

©2021 Inland Empire Health Plan. All Rights Reserved. H5355_CMC_22_2728164_C Approved

along with any supporting information with your appeal and explain why you believe the dismissal was incorrect.

2. You may request that we vacate (set aside) the dismissal action. If we determine there is good cause to vacate the dismissal because of a finding that the person who made the request is a proper party, we will vacate our dismissal and review your coverage request. Your request to vacate this dismissal must be received by our office at *<insert address/fax/phone for filing appeal requests>* within **6 months** of the date of this notice. Include a copy of this *Notice of Dismissal of Coverage Request* along with any supporting information with your request.

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.