<<IPA LOGO>>

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

Notice of Dismissal of Coverage Request

Date:

Enrollee's Name: **Enrollee ID Number:**

(Insert non-contract provider name, if applicable):

Plan Name: IEHP DualChoice (HMO D-SNP) Phone: <<IPA Phone Number>> Fax: <<IPA Fax>>

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 <<IPA>> at:

Toll Free Phone: <<IPA Number>> Days & hours of operation: <<IPA Hours of Operation>>

TTY Users Phone: <<IPA TTY>> Days & hours of operation: <<IPA Hours of Operation

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 P.O.

Box 1800 Rancho Cucamonga, CA 91729-1800 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*** 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 we found 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 <<IPA Mailing Address>> or by fax at <<IPA Fax Number>> 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 (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.