[*Date*]

[*Name of Beneficiary or Representative*]

[*Address*]

Beneficiary’s name: [*Name*] Provider Name: [*Name*]

Member ID #: [*ID #*] Requested Service: [*Service*]

Health Plan Name: SCAN [Date of Standard Request: [*Date*]]

Health Plan Phone #: (800) 559-3500 [Date of Expedited Request: [*Date*]]

Attending Physician’s Name: [*Name*] [Time of Expedited Request: [*Time*]]

Dear [*Beneficiary’s Name*]:

This correspondence is in response to you or your physician’s request for an [*expedited seventy-two (72) hour-delete if not applicable*] initial decision regarding the services noted above. We need 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 obtained. *[Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member.]*

OPTION 2: We believe that we may be able to approve the request with the additional information that is being requested. *[Medicare Advantage Organization (MAO) or its delegated provider group must explain how the need for this additional information is justified and in the interest of the member. For example, the receipt of additional medical evidence from non-contracted providers or additional tests may change an MAO’s or provider group’s decision to deny.]*

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 with your health plan if you disagree with our decision to delay its determination. The grievance process allows a member to file a complaint with the health plan about issues other than denied claims or services. Your health plan 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:

SCAN

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

 (800) 559-3500

Fax: (562) 989-0958

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 my attention at 1-(XXX)-XXX-XXXX or TDD/TTY 1-(XXX-XXXX) between the hours of [add hours of operation], or fax information to 1-(XXX)-XXX-XXXX.

Sincerely,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name

Title

C: [*Provider, if provider requested*]