[Insert Provider Name, Address, Phone Number]

Notice of Denial of Medical Coverage

**Date:** [Letter Date] **Member number:** [Member ID]

**Name:** [Member Name]

[Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service)]

**Coverage for your medical services/items was {Insert appropriate term: *partially approved,* *denied*}**

We’ve {Insert appropriate term: *denied, partially approved, stopped, reduced, suspended*} the {*payment of*} {*medical services/items or Medicare Part B drug* } listed below that you or your doctor requested:

**Why was coverage {Insert appropriate term: denied, partially approved, stopped, reduced, suspended}?**

We {Insert appropriate term: *denied, partially approved, stopped, reduced, suspended*} the {*payment of*} {*medical services/items or Medicare Part B drug* } listed above because {Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage provisions to support decision}:

Share a copy of this decision with your doctor and discuss next steps. If your doctor asked for coverage on your behalf, we already sent them a copy of this denial notice.

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

You have the right to ask SCAN to review our decision by asking us for an appeal within **65 calendar days** of the date of this notice. If you ask for an appeal after 65 days, you must explain why your appeal is late. See “How to ask for an appeal with SCAN” on the next page.

*[****How to keep your services while we review your case:*** *If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. For* ***service to continue, you must ask for an appeal*** ***within 10 days*** *of the date of this notice**or before the service is stopped or reduced, whichever is later. Your doctor must agree that you should keep getting the service. You may have to pay for these services if you lose your appeal.]*

**If you want someone else to act for you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at 1-855-827-7226 to learn how to name your representative. TTY users call 711.

**Important Information About Your Appeal Rights**

**There are 2 kinds of appeals with {health plan name}**

**Standard Appeal**

* **Request for Service**: For services you haven’t received yet, we’ll give you a written decision within {insert appropriate timeframe for medical service/item or Medicare Part B drug: *30 days, 7 days*} after we get your appeal. [insert for requests for medical service/item: *Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed*.]
* **Request for Payment**:For appeals related to payment of a {medical service/item or Medicare Part B drug} you already received, we’ll give you a written decision within 60 days. You can’t ask for a fast appeal if you’re asking us to pay you back for a {*medical service/item or Medicare Part B drug*} you already received.

**Fast Appeal (only available for service requests)**

* We’ll give you a decision on a fast appeal within 72 hoursafter we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a standard appeal.
* We’ll automatically give you a fast appeal if a doctor asks for one for you or supports your request. For a fast appeal without support from a doctor, we’ll decide whether your request requires a fast appeal. If we don’t give you a fast appeal, we’ll process a standard appeal.

**How to ask for an appeal with {health plan name}**

**Step 1:** You, your representative, or your doctor can ask for an appeal. Your {*written*} request must include:

* Your name
* Address
* Plan Member number
* Reasons for appealing
* Whether you want a standard or fast appeal (for a fast appeal, explain why you need one).
* Any evidence you want us to review, like medical records, doctor supporting statements, or other information that explains why you need the {*medical service/item or Medicare Part B drug*}.

If you’re asking for an appeal and missed the deadline, you can ask for an extension and should include your reason for being late.

Keep a copy of everything you send for your records. [Insert, if applicable: *You can ask to see the medical records and other documents we used to make our decision before or during the appeal. You can also ask for a copy of the guidelines we used to make our decision at no cost to you*.]

**Step 2:** Submit your appeal by mail, phone, fax, or online.

**For a Standard Appeal:**

Mailing Address:  
SCAN Health Plan

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

1-855-827-7226

TTY Users Call: 711

Fax:

Fax: 1-562-989-0958

Website:

www.scanhealthplan.com

In Person Delivery Address:

SCAN Health Plan

3800 Kilroy Airport Way, Suite 100

Long Beach, CA 90806

**For a Fast Appeal:**

Phone: 1-855-827-7226

TTY Users Call: 711

Fax: 1-562-989-0958

Website: www.scanhealthplan.com

**What happens next?**

If you ask for an appeal and we continue to deny your request for {*payment of*} a {*medical service/item or Medicare Part B drug* }, we’ll automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

**Get help & more information**

* SCAN Toll Free: 1-855-827-7226. TTY users call: 711. From April 1 to September 30 hours are 8 a.m. to 8 p.m., Monday through Friday. From October 1 to March 31, hours are 8 a.m. to 8 p.m., seven days a week. Or www.scanhealthplan.com.
* **Medicare:** 1-800-MEDICARE (1-800-633-4227. TTY users call: 1-877-486-2048
* **Medicare Rights Center:** 1-888-HMO-9050
* **Elder Care Locator:** 1-800-677-1116 or [Eldercare.acl.gov/Public/Index.aspx](http://Eldercare.acl.gov/Public/Index.aspx) to find help in your community
* **State Health Insurance Program:** call your State Health Insurance Assistance Program for free, personalized health insurance counseling. Visit SHIPhelp.org or call 1-877-839-2675 to get the number for your local SHIP.

**Get information in another format**

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](https://gcc02.safelinks.protection.outlook.com/?url=https%3A%2F%2Fwww.medicare.gov%2Fabout-us%2Fnondiscrimination%2Faccessibility-nondiscrimination.html&data=05%7C01%7CSabrina.Edmonston%40cms.hhs.gov%7Cf9660dff7be64273aaca08da37806d63%7Cd58addea50534a808499ba4d944910df%7C0%7C0%7C637883321967786495%7CUnknown%7CTWFpbGZsb3d8eyJWIjoiMC4wLjAwMDAiLCJQIjoiV2luMzIiLCJBTiI6Ik1haWwiLCJXVCI6Mn0%3D%7C3000%7C%7C%7C&sdata=JicYRpGPqKvuHzPrkxsak8cYevEYUNvJOAvziqekgWg%3D&reserved=0), or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.

**PRA Disclosure Statement**

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0829. This information collection is for the notice Medicare health plans must provide when a request for either a medical service or payment is denied, in whole or in part. The time required to complete this information collection is estimated to average less than 10 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. This information collection is mandatory under Section 1852(g)(1)(B) of the Act and the regulatory authority set forth in Subpart M of Part 422 at 42 CFR 422.568, 422.572, 417.600(b), and 417.840. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports ClearanceOfficer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.