**[*HEALTH PLAN OR MEDICAL GROUP/IPA LETTERHEAD*]**

**[Use 12-Point Font]**

#  Medicare Advantage

# Services Requested Do Not Meet Expedited Criteria

[*Date*]

[*Name of Patient*] Patient Name:

[*or Representative*] Patient ID #:

[*Address*] Health Plan Name: SCAN

 Health Plan Phone #: (855) 844-7226

 Provider Name:

Requested Service:

Date and Time of Expedited Request:

 Attending Physician’s Name:

Dear [*Patient’s Name*]:

This correspondence is in response to your request for an expedited seventy-two (72) hour initial decision to approve the services noted above.

We have reviewed your request and based on the information available, have determined that your request does not meet the Centers for Medicare and Medicaid Services (CMS) definition of “time sensitive”. We are required to complete our review of your request on an expedited basis if (1) your request meets the definition of “time sensitive”; or (2) a physician supports your request for an expedited review. Time sensitive is defined as “A situation where the time frame of the standard decision making process could seriously jeopardize the life or health of the enrollee, or could jeopardize the enrollee’s ability to regain maximum function.” Since your request has not met either of these two criteria, it has been forwarded to the standard review process.

We will make every effort to process your request as soon as possible but no later than fourteen (14) calendar days after the date of receipt of your request, and you will be notified once your review has been completed.

You have the right to resubmit a request for an expedited seventy-two (72) hour initial decision. If any physician supports your request for an expedited review, and the physician indicates that waiting for fourteen (14) days could seriously harm your health, the request will be expedited automatically.

You may also file an expedited oral or written grievance with your health plan regarding our decision not to expedite your review. The grievance process allows a member to file a complaint with their health plan about issues other than denied claims or services. Your health plan must respond to an expedited grievance within twenty-four (24) hours.

To file an expedited grievance, you or your authorized representative should telephone, mail or fax your written grievance to:

**SCAN**

**Attn: Grievance and Appeals Department**

**P.O. Box 22644**

**Long Beach, CA 90801-5644**

**(855) 844-7226**

**Fax: (562) 989-0958**

Also, please note that although you are not required to submit additional information to us, it is important you contact us immediately if your medical condition changes or if you have additional information pertinent to this matter.

Please direct any further questions or information to my attention at 1-(XXX)-XXX-XXXX or TDD/TTY (XXX)-XXX-XXXX between the hours of [*add the hours of operation]*.

Sincerely,

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

Name

[Title]