# [Insert Provider Name, Address, Phone Number]

# Coverage Decision Letter

***IMPORTANT:*** *For help with this notice, contact* ***SCAN Health Plan*** *at 800-559-3500 (TTY: 711)* ***OR the California Department of Health Care Services (DHCS) Office of the Ombudsman*** *at 1-888-452-8609 (TTY: 711)*

## <Date of Letter>

[Insert Member name]

[Member Address 01]

[Member Address 02]

Member Health Plan ID: [Member ID]

Service/item this letter is about: [service/item that was requested].

[Group Name] is a health care provider contracted with SCAN.

SCAN Health Plan/[provider name] is called “our plan” or “we” in this letter. SCAN is a health plan that contracts with Medicare and Medi-Cal to provide coverage for both programs. Our plan coordinates your Medicare and Medi-Cal services and your doctors, hospitals, pharmacies, and other health care providers.

### Our plan <denied *or* partially denied *or* reduced *or* stopped *or* suspended *or* changed> the <medical service/item *or* Part B drug> listed below:

[Free text - *Insert description of medical service/item or Part B drug, including the amount, duration, and scope, of what the enrollee requested (e.g., physical therapy visits 2 times per week for 1 year), and the outcome, denied, partially denied, reduced, stopped, suspended, or changed, and include the doctor or provider’s name if a particular doctor or provider requested the service or item. If a service or item request is partially denied, reduced, or changed, include specifically what was requested and what is approved (e.g., We are approving acupuncture services for 3 months instead of a full year, or We are approving moving a toilet to the south wall instead of the east wall of the bathroom, or We previously approved 18 acupuncture visits per year but are now reducing the visits to only allow 10.)*]

[*Insert this paragraph if this is a post-service case for which there is no member liability:* **Please note, you will not be billed or owe any money for this**[*insert as applicable:* **medical service/item** *or* **Part B drug**].]

Our plan made this decision because [Free text - *Provide a specific denial reason and a concise explanation of why the medical service/item or Part B drug was denied and include state or federal law and/or Evidence of Coverage/Member or Enrollee Handbook provisions to support the decision in plain language. The plain language explanation of the decision should include: (1) relevant context for the decision* *(e.g., if the medical service/item or Part B drug was approved for the enrollee in the past, the description should include what was previously approved, when it was approved and by whom, and what has changed or is otherwise different now); (2) coverage information considered including Medicare and Medi-Cal coverage benefits; and, (3) if applicable, information on how or why the requested service or item is not supported by the enrollee’s needs – see instructions for more information*].

[*Insert this paragraph if denial will result in a stoppage, suspension, or reduction of a medical service/item or Medicare Part B drug the individual has already been receiving:* **Our plan will** <**reduce** *or* **stop** *or* **suspend**> **your** <**medical service/item** *or* **Part B drug**> **on** <**effective date**>**.** See the “How to keep getting your <medical service/item *or* Medicare Part B drug > during your appeal” section later in this letter for information about continuing to receive your <medical service/item *or* Medicare Part B drug during your appeal.]

## You have the right to appeal our decision

You can appeal our plan’s decision. Share this letter with your <doctor *or* health care provider> and ask about next steps. If you appeal and our plan changes its decision, we may pay for the <medical service/item or Part B drug>.

You can also call <provider phone number for appeal requests> (TTY: <TTY number>) and ask us for a free copy of the information we used to make our decision. This may include health records, guidelines, and other documents. You should show this information to your <doctor *or* health care provider> to help you decide if you should appeal.

**You must appeal to our plan by** [*Insert specific appeal filing deadline date in month, date, year format – 60 calendar days from date of letter. Insert deadline date in bold text*]**.** Our plan may give you more time if you have a good reason.

## There are two kinds of appeals

**Our plan has two kinds of appeals – standard appeals and fast appeals.**

1. If you ask for a **standard appeal**, our plan will send you a written decision within *for a Part B drug, insert:* **7 calendar days** *or**for any other medical service/item, insert:* **30 calendar days after we get your appeal**.
2. If you ask for a **fast appeal**, our plan will give you a decision within [*insert:* **72 hours**] **after we get your appeal**. You can ask for a fast appeal if you or your <doctor *or* health care provider> believe your health could be **seriously harmed** by waiting up to [*for a Part B drug, insert:* **7 calendar days** *or**for any other medical service/item, insert:* **30 calendar days**] for a decision. Our plan will **automatically** give you a fast appeal if your<**doctor** *or* **health care provider**> **asks for one for you** or if your<**doctor** *or***health care provider**> **supports your request**.If you ask for a fast appeal without support from a <doctor *or*health care provider>, our plan will decide if you can get a fast appeal. If our plan doesn’t approve a fast appeal, we’ll give you a decision on your appeal within [*for a Part B drug, insert:* **7 calendar days** *or for any other medical service/item, insert:* **30 calendar days** ].

[*Delete this paragraph if the letter is for a denial of a Part B drug:* For both standard and fast appeals, our decision might take longer if you ask for more time or if we need more information from you. Our plan will send you a letter and tell you if we need more time and why.]

## How to appeal

You, someone you named in writing as your representative to act on your behalf (such as a relative, friend, or lawyer), or your <doctor *or* health care provider> can appeal. You can contact our plan to appeal in one of these ways:

* **Phone:** Call 1-800-559-3500 (TTY: 711)
* **Fax:** Send a fax to 1-562-989-0958
* **Mail:** Mail it to:

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

* **In person:** Deliver it to:

SCAN Health Plan
3800 Kilroy Airport Way, Suite 100

Long Beach, CA 90806

If you appeal in writing, keep a copy. If you call, we’ll send you a letter that says what you told us on the phone.

When you appeal, you must give our plan:

* Your name
* Your address or an address where we should send information about your appeal (if you don’t have a current address, you can still appeal)
* Your member number with our plan
* The reason(s) you’re appealing our decision
* If you want a standard or a fast appeal. (For a fast appeal, tell us why you need one.)
* Anything you want our plan to look at that shows why you need the <medical service/item *or* Part B drug >. For example, you can send us:
	+ Medical records from your <doctor *or* health care provider>,
	+ Letters from your <doctor *or* health care provider> (such as a statement from your <doctor *or* health care provider> that says why you need a fast appeal), or
	+ Other information that says why you need the <medical service/item *or* Part B drug>

To get more information on how to appeal, call Member Services at 1-800-559-3500 (TTY: 711). You can also find more information in our plan’s *Member Handbook (Evidence of Coverage),* Chapter 9 – What to do if you have a problem or complaint (coverage decisions, appeals, complaints). An up-to-date copy of the *Member Handbook (Evidence of Coverage)* is always available on our website at www.scanhealthplan.com or by calling our plan.

## How to keep getting your <medical service/item *or* Part B drug> during your appeal

If you’re already getting the <medical service/item *or* Medicare Part B drug> listed on the first page of this letter, you can ask to keep getting it during your appeal.

* **You must appeal and ask our plan to continue getting your** <**medical service/item** *or* **Medicare Part B drug**> **by** [*Insert continuation of benefits request filing date in month, date, year format. Date will be the later of the following: (1) 10 calendar days from date of letter (or later than 10 calendar days, if required by the state) or (2) date the decision takes effect. Insert date in bold text*]**.**
* See the “How to appeal” section earlier in this letter for information about how to contact our plan.
* If you ask our plan to continue your <medical service/item *or* Medicare Part B drug> by [*Insert continuation of benefits request filing date*], your <medical service/item *or* Medicare Part B drug> will stay the same during your appeal.
* If your <doctor *or* health care provider> is filing the appeal for you and you want to keep getting your <medical service/item *or* Medicare Part B drug>, then your <doctor *or* health care provider> must include your written consent.]

## What happens next

After you appeal, our plan will send you an appeal decision letter to tell you if we approve or deny your appeal. If our plan still denies the <medical service/item*or* Part B drug> listed on the first page of this Coverage Decision Letter, the appeal decision letter will tell you what happens next, such as information about a Medicare Level 2 appeal or how to ask California for a Fair Hearing also called a State Fair Hearing.

## What to do if you need help with your appeal

You can get someone to appeal for you and act on your behalf. You must first name them in writing as your “representative” by following the steps below. Your representative can be a relative, friend, lawyer, doctor, health care provider, or someone else you trust.

If you want someone to appeal for you:

* Call our plan at 1-800-559-3500 (TTY: 711) to learn how to name that person as your representative. Or, you can visit <https://www.medicare.gov/claims-appeals/file-an-appeal/can-someone-file-an-appeal-for-me>.
* You and your representative must sign and date a statement that says this is what you want.
* Mail or fax the signed statement to us at:

SCAN Health Plan

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

Fax: 1-562-989-0958

* Keep a copy.

## Get help and more information

* SCAN Health Plan **Member Services:** Call 1-800-559-3500 (TTY: 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. You can also visit [www.scanhealthplan.com](http://www.scanhealthplan.com).
* **California Department of Health Care Services (DHCS) Office of the Ombudsman**: Call 1-888-452-8609 (TTY: 711). The Office of the Ombudsman can answer questions if you have a problem with your appeal. They can also help you understand what to do next. They aren’t connected with our plan or with any insurance company or health plan. Their services are free.
* **The Health Insurance Counseling & Advocacy Program (HICAP):** Call:
1-800-434-0222. HICAP counselors can help you with Medicare issues, including how to appeal. HICAP isn’t connected with any insurance company or health plan. Their services are free.
* **Medicare:** Call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week (TTY users can call 1-877-486-2048). Or, visit [Medicare.gov](http://www.Medicare.gov).
* **Medi-Cal Managed Care and Mental Health Office of the Ombudsman:** Call
1-888-452-8609.
* **Medicare Rights Center:** Call 1-800-333-4114, or visit [www.medicarerights.org](http://www.medicarerights.org/).
* **Eldercare Locator**: Call 1-800-677-1116, or visit [www.eldercare.acl.gov](http://www.eldercare.acl.gov) to find help in your community.

You can get this document for free in Spanish or Chinese other formats, such as large print, braille, or audio. Call 1-800-559-3500 (TTY: 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. The call is free.

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, or call 1-800-MEDICARE (1-800-633-4227) for more information. TTY users can call 1-877-486-2048.