[Insert Provider Name, Address, Phone Number]

**Important:** This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under “Get help & more information.”

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)]

**Your request was [Insert appropriate term: partially approved, denied].**

We’ve [Insert appropriate term: denied, partially approved, stopped, reduced, suspended] the medical services/items or Part B drug listed below requested by you or your doctor, [provider name]:

[Free text]

**Why did we deny your request?**

We [Insert appropriate term: denied, partially approved, stopped, reduced, suspended] the medical services/items or 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]:

[Free text]

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

**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**.**

**Plan Appeal:** Ask SCAN for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for an appeal with SCAN” for information on how to ask for a plan level 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 SCAN at: 1-800-559-3500 to learn how to name your representative. TTY users call 711. Both you and the person you want to act for you must sign and date a statement confirming this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

**Important Information About Your Appeal Rights**

***There are 2 kinds of appeals with SCAN***

**Standard Appeal –** We’ll give you a written decision on a standard appeal within ***30 days*** for a service/item or ***7 days*** for a Part B drug after we get your appeal. 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. If your appeal is for payment of a medical service/item or Part B drug you’ve already received, we’ll give you a written decision within **60 days**.

**Fast Appeal** – We’ll give you a decision on a fast appeal within **72 hours** after 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 up to **30 days** for a medical service/item or **7 days** for a Part B drug for a decision. You cannot request an expedited appeal if you are asking us to pay you back for a medical service/item or Part B drug you’ve already received.

**We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request.** If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within **30 days** for a medical service/item or **7 days** for a Part B drug.

**How to ask for an appeal with SCAN**

**Step 1:** You, your representative, or your doctor, [provider name] must ask us for an appeal. Your written request must include:

* Your name
* Address
* 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, such as medical records, doctors’ letters (such as a doctor’s supporting statement if you request a fast appeal), or other information that explains why you need the medical service/item or Part B drug. Call your doctor if you need this information.

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

We recommend keeping a copy of everything you send us for your records. You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal. You can also call us or submit your appeal electronically.

**For a Standard Appeal:**

Mailing Address:

SCAN

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

1-800-559-3500

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: 1-800-559-3500

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 a medical service/item or 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: 1-800-559-3500. 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.
* 1-800-MEDICARE (1-800-633-4227), 24 hours, 7 days a week. TTY users call:
1-877-486-2048.
* Medicare Rights Center: 1-888-HMO-9050.
* Elder Care Locator: 1-800-677-1116 or www.eldercare.acl.gov to find help in your community.

**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 collection is 0938-0829. The time required to complete this information collection is estimated to average 10 minutes per response, including the time to review instructions, search existing data resources, and gather the data needed, and complete and review the information collection. If you have any 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 Clearance Officer, Baltimore, Maryland 21244-1850.

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.