[Insert Provider Name, Address, Phone Number]

**Notice of Dismissal of Coverage Request**

**Date:** [Date]

**Enrollee’s Name:** [Name of Member]

**Enrollee’s Address:** [Address]

**Enrollee ID Number:** [SCAN Member ID]

|  |  |
| --- | --- |
| Health Plan Name: SCAN Health Plan | Phone: 1-800-559-3500 (TTY: 711) |

We dismissed the coverage request you filed on[insert date].

We can’t process your request because: *[explain the specific reason for dismissal and what is missing from the request -- e.g., person making the request is not a proper party and there isn’t an appointment of representation (AOR) form.* *See* [*42 CFR §§ 422.568(g)*](https://www.ecfr.gov/current/title-42/part-422/section-422.568#p-422.568(g))*,* [*422.631(e)*](https://www.ecfr.gov/current/title-42/part-422/section-422.631#p-422.631(e))*,* [*423.568(i)*](https://www.ecfr.gov/current/title-42/part-423/section-423.568#p-423.568(i)) *and the* [*Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*](https://www.cms.gov/medicare/appeals-grievances/prescription-drug) *for when it may be appropriate to dismiss a coverage request.]*

[For inadequate AOR:] The Appointment of Representative (AOR) form submitted with the request is not currently valid. [Free text: Include Why/What is missing in the form to make it invalid (examples: no signature; out of date) is missing.] Please submit an updated AOR form.

[For invalid requestor:] The person or entity who made the request is not permitted to make such a request for you without the receipt of an adequate Appointment of Representative (AOR) form. Please fill out and submit a current AOR form.

[For death – request from physician:] We have been informed that this member has passed away. Please contact SCAN if this information is inaccurate.

[For timely verbal/written request for withdrawal of their initial determination request:] We have received a request to withdraw the original request.

**What to do next**

**If you disagree with our decision to dismiss your coverage request,** you have two options:

1. If you think we have incorrectly dismissed your coverage request (for example, you believe <*insert reason* (e.g., you are a proper party)>), you may request that we review our dismissal. Your appeal must be received by us at the following addresswithin **65 calendar days** of the date of this dismissal notice. **Include a copy of this *Notice of Dismissal of Coverage Request***along with any supporting information with your appeal and explain why you believe the dismissal was incorrect. Contact our Grievance and Appeals Department to make your appeal.

SCAN Health Plan

Attn: Grievance and Appeals Department

P.O. Box 22644

Long Beach, CA 90801-5644

Tel: 1-800-559-3500

TTY Users Call: 711

Fax: 1-562-989-0958

1. You can ask us to set aside (vacate) the dismissal action. If we determine there is good cause to vacate the dismissal because [*insert reason* *for finding good cause--e.g., a finding that the person who made the request is a proper party*], we will vacate our dismissal and review your coverage request. Your request to vacate this dismissal must be received by our office at the following addresswithin **6 months** of the date of this notice. Include a copy of this *Notice of Dismissal of Coverage Request* along with any supporting information with your request.

[Insert Provider Name, Address, Phone Number, Fax Number]

If you have any questions about this notice, please contact:

SCAN Member Services

Call them at 1-800-559-3500 (TTY: 711).

* Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week.
* Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday.
* Messages received on holidays and outside of our business hours will be returned within one business day.

[C: Requesting Provider Name]

[Requesting Provider Address]

[C: PCP]

[PCP Address]