ACKNOWLEDGEMENT OF APPEAL
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Acknowledgement of appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file an appeal about (issue):

_____

_____

_____

_____

_____

What Happens Next?

[Choose one of the sentences below based upon if AOR or VV is needed]
[If ***no*** AOR/VV is needed:] We will review your case. We will give you a decision no later than 30 calendar days after we got your appeal request. If you do not get a decision within 30 calendar days, you have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State administrative hearing.

[If AOR and/or VV is needed:] We need the attached form(s) to start your appeal.

☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked us for an appeal for you and we need your okay to review the appeal. This form lets you choose someone to act as your Representative for this appeal. We need you to fill out and sign this form. Send it back to us by (Date) using the envelope we gave you. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after we receive your completed form.

☐ **Verbal Verification** – This form is needed when you ask for an appeal verbally. Your appeal needs to be in writing. We need you to sign and send this form to us by (Date). If a written statement is not received within the timeframe, we will be unable to process your

request. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after you first spoke to us to ask for an appeal.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address, this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF APPEAL
[Health Plan Logo]

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file an appeal about (issue):

_____
_____
_____
_____
_____

What Happens Next?

[Choose one of the sentences below based upon if AOR or VV is needed]
If ***no*** AOR/VV is needed: We will review your case. We will give you a decision no later than 30 calendar days after we got your appeal request. If you do not get a decision within 30 calendar days, you have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State Administrative hearing.

If AOR and/or VV is needed: We need the attached form(s) to start your appeal.
☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked us for an appeal for you and we need your okay to review the appeal. This form lets you choose someone to act as your Representative for this appeal. We need you to fill out and sign this form. Send it back to us by (Date) using the envelope we gave you. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after we receive your completed form.

☐ **Verbal Verification** – This form is needed when you ask for an appeal verbally. Your appeal needs to be in writing. We need you to sign and send this form to us by (Date). If a written statement is not received within the timeframe, we will be unable to process your request. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after you first spoke to us to ask for an appeal.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or PO box)

[Language Block]

ACKNOWLEDGEMENT OF GRIEVANCE
[Health Plan Logo]

[Date]

[Name] Member number:
[Address of member] Reference/Case number:

Re: Acknowledgement of grievance

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file a grievance about (issue):

_____
_____
_____
_____

If you do not agree with the grievance information stated above, please tell us below. Your response is due to us within 5 business days after you receive the acknowledgement letter.

_____
_____
_____
_____

What Happens Next?

[Choose one of the sentences below based upon if AOR or VV is needed]
[If ***no*** AOR/VV is needed:] We will review your case. We will give you a decision no later than 30 calendar days after we got your grievance request.

[If AOR and/or VV is needed:] We need the attached form(s) to notify anyone other than you of the resolution of your grievance.
☐ **Appointment of Representative** – Your provider asked to file a grievance for you and we need your okay to review the grievance. This form allows your provider to act as your representative for this grievance. We need you to fill out and sign this form. Send it back to us by (date) using the envelope we gave to you. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after we receive your completed form.

☐ **Verbal Verification** – This form is needed when you ask for a grievance verbally. Your grievance needs to be in writing. We need you to sign and send this form to us by (Date). If a written statement is not received within the timeframe, we will be unable to process your request. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after you first spoke to us to ask for a grievance.

You can send in any information to help you with your grievance. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or PO box)

Signature:

cc: Member (When applicable)

[Language Block]

ACKNOWLEDGEMENT OF GRIEVANCE
[Health Plan Logo]

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] got your (insert appropriate term: letter, phone call) on (date received) telling us you want to file a grievance about (issue):

_____

_____

_____

_____

If you do not agree with the grievance information stated above, please tell us below. Your response is due to us within 5 business days after you receive the acknowledgement letter.

_____

_____

_____

_____

What Happens Next?

[Choose one of the sentence below based upon if AOR or VV is needed]
[If ***no*** AOR/VV is needed:] We will review your case. We will give you a decision no later than 30 days after we got your grievance request.

[If AOR and/or VV is needed:] We need the attached form(s) to notify anyone other than you of the resolution of your grievance.

☐ **Appointment of Representative** – Your provider asked to file a grievance for you and we need your okay to review the grievance. This form allows your provider to act as your representative for this grievance. We need you to fill out and sign this form. Send it back to us by (date) using the envelope we gave to you. When we receive this form, we will review your case. We will give you a decision no later than 30 days after we receive your completed form.

☐ **Verbal Verification** – This form is needed when you ask for a grievance verbally. Your grievance needs to be in writing. We need you to sign and send this form to us by (Date). If a written statement is not received within the timeframe, we will be unable to process your request. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after you first spoke to us to ask for a grievance.

You can send in any information to help you with your grievance. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file. Use the contact information below if you need help or want to give us information.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert mailing address this may be a Physical address or PO box)

[Language Block]

APPOINTMENT OF REPRESENTATIVE
[Health Plan Logo]

Date: **Member number:**

Name: **Reference/Case number:**

PART 1 --- APPOINTMENT OF REPRESENTATIVE (to be filled out by Member)

I allow _____ to act for me when filing a
(Name of person you want as your representative)
grievance, claim or appeal.

The person I have named can act for me when giving or receiving any information about my grievance, claim or appeal. This includes personal medical information.

Member:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

PART 2 --- ACCEPTANCE OF APPOINTMENT (to be filled out by Representative)

_____ , accept the appointment. I will
(Name of person who will be member's representative)
act on behalf of the member to file a grievance, claim or appeal.

Relationship to Member: (Must be age 18 or older)	
Representative Signature:	Date:
Street Address:	Telephone (with area code):
City:	State: ZIP Code:

This authorization is good for one year from the date you sign this form unless you tell us the following:

Date: _____/_____/_____Or Event: _____
Month Day Year

Part 3 ---YOUR INDIVIDUAL RIGHTS (Please read):

I understand that:

- I do not have to sign this form.
- I can cancel this form by writing to [Health Plan] at the address below except for the information that was already disclosed.
- Once my protected health information is disclosed to the person or organization I specified in **Part 1** of this form, the information in their possession may no longer be protected by privacy laws.

Please complete this form. Mail, fax, or deliver this form to the address below:

[Health Plan name]

[Address – Physical address or PO box]

[Fax number]

Member Signature: _____ Date: _____

[Language Block]

DENIAL OF FAST APPEAL
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Denial of fast appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your request for a fast appeal on (Date received) about (issue):

_____

_____

_____

_____

We will not do a fast review of your appeal because:

_____

_____

_____

What Happens Next?

We will review your case as a standard appeal. We will decide your appeal within 30 calendar days after we got your appeal request. We will give you a decision by (Insert date).

If you do not agree with our decision to review your case as a standard appeal, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

[If AOR is needed:] We need the attached form to start your appeal.

☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked us for an appeal for you and we need your okay to review the appeal. This form lets you choose someone to act as your Representative for this appeal. We need you to fill out and sign this form. Send it back to us by (Date) using the envelope we gave to you. When we receive this form, we will review your case. We will give you a decision no later than 30 days after we receive your completed form.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file.

Contact Information:
If you need information or help, or to give us more information about your appeal, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)

Signature:
cc: Member (When applicable)

[Language Block]

DENIAL OF FAST APPEAL
[Health Plan Logo]

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] got your request for a fast appeal on (Date received) about (issue):

We will not do a fast review of your appeal because:

What Happens Next?

We will review your case as a standard appeal. We will decide your appeal within 30 calendar days after we got your appeal request. We will give you a decision by (Insert date).

If you do not agree with our decision to review your case as a standard appeal, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health Plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

[If AOR is needed:] We need the attached form to start your appeal.

☐ **Appointment of Representative** – Your (insert appropriate term: e.g. doctor, husband, daughter) asked us for an appeal for you and we need your okay to review the appeal. This form lets you choose someone to act as your Representative for this appeal. We need you to fill out and sign this form. Send it back to us by (Date) using the envelope we gave to you. When we receive this form, we will review your case. We will give you a decision no later than 30 calendar days after we receive your completed form.

You can send in any information to help you with your appeal. You can send in this information or give us this information in person. At no cost to you, you may also ask for a copy of your file.

Contact Information:
If you need information or help, or to give us more information about your appeal, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)

[Language Block]

EXTENSION OF APPEAL RESOLUTION
[Health Plan Logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Extension of appeal resolution

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] got your appeal on (Date received) about (issue):

_____

_____

_____

_____

_____

We need more time to look at your case. We have not made a decision yet because (Insert reason for delay). Taking more time is in your best interest. We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (When applicable)

[Language Block]

EXTENSION OF APPEAL RESOLUTION
[health plan logo]

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] got your appeal on (Date received) about (issue):

_____

_____

_____

_____

_____

We need more time to look at your case. We have not made a decision yet because (Insert reason for delay). Taking more time is in your best interest. We may take up to 14 more calendar days. We will give you a decision by (Insert date).

If you do not agree with the 14 calendar day extension, you have the right to file a grievance with (health plan name). You can ask for or send in a written grievance. We will review your grievance and give you a decision no later than 30 calendar days after we get your request. To file a grievance: Call, mail, fax, or deliver your grievance Monday through Friday, 7:45 am to 4:30 pm Hawaii time, to:

[Health plan name]
[Address – Physical address or PO box]
[Toll-free phone]
[TDD/TYY]
[Fax number]

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

[Language block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF PAYMENT
[health plan logo]

(Notice only – This is not a bill)

[Date]

[Member's Name] Member number:
[Address of member] Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Payment

Dear [Member's name]:

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about our decision whether to pay for a service you received.

We recently received a claim for <<service(s)>>

provided to you by <<provider name>>
on <<date(s) of service(s)>>.

We will not pay for <<service(s)>>

because (Insert appropriate reason: "the request did not meet the established medical necessity criteria or guidelines at this time." "the service is not a covered service under Medicaid/The Plan." or other reason)

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.
We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

Signature: (Medical Director)
cc: Member (when applicable)
[Language block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

Standard (30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

What Happens Next?
If you appeal we will review our decision again. After you get our decision, if you still disagree with the decision you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF PAYMENT
[health plan logo]

(Notice only - This is not a bill)

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about our decision whether to pay for a service you received.

We recently received a claim for <<service(s)>>

provided to you by <<provider name>>

on <<date(s) of service(s)>>.

We will not pay for <<service(s)>>

because (Insert appropriate reason: "the request did not meet the established medical necessity criteria or guidelines at this time." "the service is not a covered service under Medicaid/The Plan." or other reason)

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

We have also told <<provider>> that we will not pay for (Insert appropriate term: this, these) <<service(s)>>.

[Language block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

Standard (30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

What Happens Next?
If you appeal we will review our decision again. After you get our decision, if you still disagree with the decision you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

RESOLUTION OF APPEAL
[Health plan logo]

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] received your written appeal on (Date received) about (issue):

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist/ appeals committee]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, include title/qualifications/specialty, and any source used during the review)

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

You have a right to get copies of all the documents that were a part of this review. You may also get a copy of the standards on which this decision was based free of charge.

What If I Do Not Agree With This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State administrative hearing. File your request for a State administrative hearing in writing within 120 calendar days of the date of this notice. Send it to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

How Do I Request for Services to Continue during a State administrative hearing?

If the services you appealed about had already been approved and the health plan decided to stop, reduce or suspend them, you can ask that they continue during the State administrative hearing process. To do this:

- You must ask for services to continue during the State administrative hearing. Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date services will be changed; whichever date is later.
- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
- The original approval (authorization) period for your services has not ended.

If the State administrative hearing decision is the same as the appeal decision (to deny, stop, or reduce the services), you may have to pay for the services that you asked us to continue during the State administrative hearing process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:

cc: Member (when applicable)

[Language Block]

RESOLUTION OF APPEAL
[Health plan logo]

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] received your written appeal on (Date received) about (issue):

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist/ appeals committee]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, include title/qualifications/specialty, and any source used during the review)

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

You have a right to get copies of all the documents that were a part of this review. You may also get a copy of the standards on which this decision was based at no cost to you.

What If I Do Not Agree With This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a State administrative hearing. File your request for a State administrative hearing in writing within 120 days of the date of this notice. Send it to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

How Do I Request for Services to Continue during a State administrative hearing?

If the services you appealed about had already been approved and the health plan decided to stop, reduce or suspend them, you can ask that they continue during the State administrative hearing process. To do this:

- You must ask for services to continue during the State administrative hearing. Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 days from when the health plan mailed this final appeal decision, or by the date services will be changed; or whichever date is later.
- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
- The original approval (authorization) period for your services has not ended.

If the State administrative hearing decision is the same as the appeal decision (to deny, stop, or reduce the services), you may have to pay for the services that you asked us to continue during the State administrative hearing process.

What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

[Language Block]

RESOLUTION OF FAST APPEAL
(Health Plan Logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of fast appeal

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] received your (Insert appropriate term: oral, written) request for a fast appeal on (Date received) about (issue):

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, and any source used during the review, date verbal notification was conducted (or date message left))

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

You have a right to get copies of all the documents that were a part of this review. You may also get a copy of the standards on which this decision was based free of charge.

What If I Do Not Agree With This Decision?

You have the right to ask the State of Hawaii Department of Human Services, Administrative Appeals Office, for a fast State administrative hearing. File your request for a fast State administrative hearing in writing within 120 calendar days of the date of this notice. Send it to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

How Do I Request for Services to Continue during a fast State administrative hearing?

If the services you appealed about had already been approved and the health plan decided to stop, reduce or suspend them, you can ask that they continue during the State administrative hearing process. To do this:

- You must ask for services to continue during the State administrative hearing. Do this when you ask for your hearing.
- Your request for an administrative hearing must be filed within 10 calendar days from when the health plan mailed this final appeal decision, or by the date services will be changed; or whichever date is later.
- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
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Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (when applicable)

[Language Block]

RESOLUTION OF FAST APPEAL
(Health Plan Logo)

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting approved by MQD]
[Health plan name] received your (Insert appropriate term: oral, written) request for a fast appeal on (Date received) about (issue):

_____

_____

_____

The request has been reviewed. The review was completed by a [licensed doctor/licensed dentist]. The [doctor(s)/dentist] is/are also board certified. The [doctor(s)/dentist] was not a part of the first review or the findings from that review.

The Medical Director(s) involved is/are [Board Certified MD/DO with a specialty in [List Specialty and Title]].

What Is Our Decision?

(Insert decision here. Include: Date review was completed, department and/or staff involved, and any source used during the review, date verbal notification was conducted (or date message left))

Your medical records that we had available were reviewed. The first decision [First Determination] has been [upheld/overturned] based on this review. This denial was [upheld/overturned] because [List Reasons]. [The reasons for denial are based on a set of standards/criteria. This included [List Standards/Criteria]].

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Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

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- Your original appeal must be about services or treatment that was already approved that the health plan decided to stop, reduce or suspend before it was completed.
- The services must have been ordered by an authorized provider.
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What Happens Next?

When the Administrative Appeals Office gets your request for a hearing, they will write to you and tell you more about the hearing process. If the decision to stop, reduce or suspend services is reversed, you will receive services right away.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

[Language Block]

VERBAL VERIFICATION
(Health Plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Verbal verification

Dear (Insert name):

[Health plan greeting with MQD approval]
[Health plan name] got your verbal request for an appeal on (Date received) about (issue)

_____
_____
_____
_____
_____

We need your appeal to be in writing. You must sign, date, and send a verification of your verbal appeal back to us by (Due date). If a written statement is not received within the timeframe, we will be unable to process your request.

☐ Check here, if you agree with the information above.

If you would like to add or correct the appeal information stated above, please tell us below:

_____
_____
_____
_____
_____

Please sign below. Mail, fax, or deliver your written request to the address below using the envelope that we provided:

(Health Plan name)
(Address – Physical address or PO box)
(Fax number)

_____ _____
Signature Date

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)

Signature:
cc: Member (when applicable)

[Language Block]

VERBAL VERIFICATION
(Health Plan logo)

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting with MQD approval]
[Health plan name] got your verbal request for an appeal on (Date received) about (issue)

We need your appeal to be in writing. You must sign, date, and send a verification of your verbal appeal back to us by (Due date). If a written statement is not received within the timeframe, we will be unable to process your request.

☐ Check here, if you agree with the information above.

If you would like to add or correct the appeal information stated above, please tell us below:

Please sign below. Mail, fax, or deliver your written request to the address below using the envelope that we provided:

(Health Plan name)
(Address – Physical address or PO box)
(Fax number)

Signature Date

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)

[Language Block]

RESOLUTION OF GRIEVANCE
(Health plan logo)

[Date]

[Name]
[Address of member]

Member number:
Reference/Case number:

Re: Resolution of grievance

Dear (Insert name):

[Health plan greeting with MQD approval]
[Health plan name] received your (Insert appropriate term: written, oral) grievance on (Date received) about (issue)

_____
_____
_____
_____

What is the Result?

(Insert resolution here. Include: Date review was completed, findings/resolution/ outcomes, department and/or staff involved, and any source used during the review)

_____
_____
_____
_____

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

What If I Do Not Agree With This Result?

You have the right to ask the Med-QUEST Division for a State grievance review. File your request for a State grievance review by writing or calling them within 30 calendar days of the date of this notice. **Here is the address and phone number to use:**

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190

Kapolei, HI 96709-0190
or call: (808) 692-8094

What Happens Next?

If you ask for a State grievance review, the Med-QUEST Division will review your grievance and give you a decision within 90 calendar days after they get your grievance review request. The grievance review decision made by the Med-QUEST Division will be final. You will not have any other grievance rights after that.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

Signature:
cc: Member (when applicable)

[Language Block]

RESOLUTION OF GRIEVANCE
(Health plan logo)

Date: **Member number:**

Name: **Reference/Case number:**

[Health plan greeting with MQD approval]
[Health plan name] received your (Insert appropriate term: written, oral) grievance on (Date received) about (issue)

What is the Result?

(Insert resolution here. Include: Date review was completed, findings/resolution/ outcomes, department and/or staff involved, and any source used during the review)

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

What If I Do Not Agree With This Result?

You have the right to ask the Med-QUEST Division for a State grievance review. File your request for a State grievance review by writing or calling them within 30 calendar days of the date of this notice. **Here is the address and phone number to use:**

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190
or call: (808) 692-8094

What Happens Next?

If you ask for a State grievance review, the Med-QUEST Division will review your grievance

and give you a decision within 90 calendar days after they get your grievance review request. The grievance review decision made by the Med-QUEST Division will be final. You will not have any other grievance rights after that.

Contact Information:

If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:

Toll-free: (Insert number)
TDD/TYY: (Insert number)
Fax: (Insert number)
Mail: (Insert address this may be a Physical address or PO box)

[Language Block]

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE
(health plan logo)

[Date]

[Name] Member number:
[Address of member] Reference/Case number:

Re: Notice of Adverse Benefit Determination – Denial of Service

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

_____

_____

_____

_____

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

_____

_____

_____

_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

Signature: (Medical Director)
cc: PCP, Service Provider, and Service Coordinator (when applicable)

[Language Block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL

There are two kinds of appeals you can file:

Standard (30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

How Do I Request for Services to Continue During My Appeal?
ALL of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

(If you lose your appeal, you may have to pay for these services that you asked us to continue.)

What Happens Next?
If you appeal, we will review our decision again. If we decide to continue your services without any changes, you will receive services right away. If we decide again that your services should be stopped, reduced or suspended, and you still disagree with that decision, you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE
(health plan logo)

Date: **Member number:**

Name: **Reference/case number:**

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you are receiving. We have (Insert appropriate term: stopped, reduced, suspended) coverage of the following medical services or items that you have been receiving:

_____

_____

_____

_____

We will make this change to your services on (EFFECTIVE DATE OF CHANGE).

[Your transition plan to (insert appropriate term: stop, reduce, suspend) services is (insert information about transition plan).]

We made the decision to (Insert appropriate term: stop, reduce, suspend) this service because:

_____

_____

_____

_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days after the date of this notice. If you want your services to continue during the appeal, all of the following must be met:

- You must ask for services to continue when you give us your appeal;
- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

[Language Block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

There are two kinds of appeals you can file:

Standard (30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 more calendar days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

- **If your doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor says that waiting for 30 calendar days could seriously harm your health, **we will give you a fast appeal.**
- If you ask for a fast appeal without information from your doctor, we will decide if your health requires a fast appeal. We will notify you if we do not give you a fast appeal, and we will decide your appeal within 30 calendar days.

What do I include with my appeal?
Your written request should include: your name, address, member number, reasons you disagree with our decision, and any other information you wish to attach. If you ask for a fast appeal you will have a very short time to give us your information. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send us this information or give it to us in person.

- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

How Do I Request for Services to Continue During My Appeal?
ALL of the following must be met:

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- Your appeal must be filed within 10 calendar days of this Notice of Adverse Benefit Determination or by the date services will be changed, whichever is later;
- Your appeal must involve stopping, reducing or suspending services or treatments that were already approved;
- The services must have been ordered by an authorized provider; and
- The original authorization period cannot have ended yet.

(If you lose your appeal, you may have to pay for these services that you asked us to continue.)

What Happens Next?
If you appeal, we will review our decision again. If we decide to give you your services, you will receive services right away. If we decide again that your services should not be given to you and you still disagree with that decision, you will have the right to request a State administrative hearing . You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY:

NOTICE OF ADVERSE BENEFIT DETERMINATION
DENIAL OF SERVICE AUTHORIZATION REQUEST
(Health plan logo)

[Date]

[Name] Member number:
[Address of member] Reference/case number:

Re: Notice of Adverse Benefit Determination – Denial of Service Authorization Request

Dear (Insert name):

[Health plan greeting approved by MQD]
[Health plan name] is sending you this letter to tell you about a decision we made about services you or your doctor requested. We have decided to deny the request for coverage of the following medical services or items:

_____
_____
_____
_____
_____
_____

We made the decision to deny this service because:

_____
_____
_____
_____
_____
_____

What If I Do Not Agree With This Decision?

You have the right to ask (health plan name) for an appeal. File your appeal in writing within 60 calendar days of the date of this notice.

Who May File An Appeal?

You or your treating physician may file an appeal. Or you may name a relative, friend, advocate, attorney, doctor (other than your treating physician), or someone else to act as your representative.

You can call us toll-free at: _____ to learn how to name your representative. If you have a hearing or speech impairment, please call us at TDD/TTY: _____.

If you want someone to act for you, you and your representative must sign, date, and send us a statement naming that person to act for you.

You have a right to get copies of all the documents that were a part of this review. At no cost to you, you may also get a copy of the standards on which this decision was based free of charge.

Signature: (Medical Director)
cc: Member (when applicable)

[Language Block at end of document]

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

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Standard (30 calendar days) – You can ask for a standard appeal. If you ask for this appeal by telephone, you must also send in a written request. We will give you a decision no later than 30 calendar days after we get your appeal request. (We may take up to 14 calendar more days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

Fast (72 hours) – You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting up to 30 calendar days for a decision. We will decide on a fast appeal no later than 72 hours after we get your appeal request. (We may take up to 14 calendar more days, if you request more time, or if we need additional information. Taking more time may benefit you in our decision.)

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What do I include with my appeal?
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- You may see your medical records and other documents we used to make our decision before or during your appeal. At no cost to you, you may also ask for a copy of the guidelines we used to make our decision.

How Do I File An Appeal?

For a Standard Appeal: Mail, fax, or deliver your
written appeal to the address below:

Address:

Fax:
Toll-Free Phone:
TDD/TTY:

For a Fast Appeal: Contact us by telephone or fax:

Toll-Free Phone:
TDD/TTY:
Fax:

What Happens Next?
If you appeal, we will review our decision again. If we decide to give you your services, you will receive services right away. If we decide again that your services should not be given to you and you still disagree with that decision, you will have the right to request a State administrative hearing. You will be notified of those rights if this happens.

Contact Information:
If you need information or help, call us Monday through Friday, 7:45 am to 4:30 pm Hawaii time at:
Toll-Free Phone:
TDD/TTY: