[MCO/MLTC and UR AGENT/BENEFIT MANAGER DUAL LETTERHEAD]
[MCO/MLTC NAME] [UR AGENT/BENEFIT MANAGER Name]
[Address]
[Phone]

COMPLAINT RESOLUTION NOTICE

[Date]

[Enrollee]
[Address]
[City, State Zip]

Enrollee ID: [ID number or CIN]
{*insert if complaint is regarding a provider*} Provider: [Provider]
Plan Reference Number: [plan reference number]

Dear [Enrollee]:

You are getting this notice because you filed a complaint with [Plan] [UR Agent Name] on [Date]. [Insert summary of complaint.]

We have reviewed your complaint.

[Insert response and detailed reason for complaint determination without releasing protected peer review information, including, if applicable, the clinical rationale (which must include the basis for the determination demonstrating review of enrollee specific clinical information, and be sufficiently specific to enable the enrollee to determine the basis for appeal) OR a written statement that not enough information was presented or available to reach a determination and the time to review the complaint has expired.]

[Insert any action the MCO/UR Agent will take in response to the complaint.]

What if I don't agree with this decision?

If you think our decision is wrong, you can tell us why and ask us to review your complaint again. This is called a **Complaint Appeal.** There is no penalty and your plan will not treat you differently because you asked for a Complaint Appeal.

You have **60 working days** from getting this notice to ask for a Complaint Appeal.

Who can ask for a Complaint Appeal?

You can ask for a Complaint Appeal, or have someone else ask for you, like a family member, friend, doctor, or lawyer. If you told us before that someone may represent you, that person may ask for the Complaint Appeal. If you want someone new to act for you, you and that person must sign and date a statement saying this is what you want. Or, you can both sign and date the attached Complaint

Appeal Request Form. If you have any questions about choosing someone to act for you, call us at: [phone number]. TTY users call [TTY number].

{*Insert for all MLTCP/MAP/HARP; Insert for MA/MMC/HIV SNP only when services are LTSS or Delete*} [You can also call the Independent Consumer Advocacy Network (ICAN) to get free, independent advice about your coverage, complaints, and appeals' options. They can help you manage the appeal process. Contact ICAN to learn more about their services:

Independent Consumer Advocacy Network (ICAN)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-844-614-8800 (**TTY Relay Service**: 711)
Web: www.icannys.org | **Email**: ican@cssny.org]

{*Insert for MA/MMC/HIV-SNP for non-LTSS Services or Delete*} [For advice about your coverage or help filing a complaint or appeal, you can contact Community Health Advocates (CHA) at:

Community Health Advocates (CHA)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service**: 711)
Web: www.communityhealthadvocates.org | **Email**: cha@cssny.org]

Are you having trouble getting the substance use disorder or mental health services that you need? The Community Health Access to Addiction and Mental healthcare Project (CHAMP) is an ombudsman program that can help you with insurance rights and getting coverage for your care. CHAMP can help! Contact:

Community Health Access to Addiction and Mental Healthcare Project (CHAMP)
Community Service Society of New York
633 Third Ave, 10th Floor
New York, NY 10017
Phone: 1-888-614-5400 (**TTY Relay Service**: 711)
Web: https://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ
Email: ombuds@oasas.ny.gov

How do I ask for a Complaint Appeal?

You can call, write or visit us to ask for a Complaint Appeal. You or your provider can ask for your Complaint Appeal to be **fast tracked** if you think a delay will cause harm to your health. **If you need help, or need a Complaint Appeal right away, call us at [1-800-MCO-PLAN].**

Step 1 – Gather your information.

When you ask for a Complaint Appeal, or soon after, you will need to give us:

- Your name and address

- Enrollee number
- Reason(s) for appealing
- Any information that you want us to review to support your complaint, such as medical records, doctors' letters or other information that explains why you disagree with our response.

Step 2 – Send us your Complaint Appeal.
{*If the plan has different contact information for Complaint Appeals, plans may replace/revise the contact information below.*}
Give us your information by phone, fax, email, mail, online, or in person:

Phone…… [phone number]
Fax…… [fax number]
Email…… [email address]
Mail…… [Relevant Department][address] [city, state zip]
Online…… [web portal]
In Person…… [address] [city, state zip]

Keep a copy of everything for your records.

What happens next?

We will tell you we received your Complaint Appeal and begin our review. If you asked to present information in person, [plan name] will contact you (and your representative, if any).

We will answer your Complaint Appeal in writing within 30 working days after we receive all necessary information. If a delay will harm your health, we will answer within 2 working days.

Other Help:

You can file a complaint about your managed care at any time with the New York State Department of Health by calling {for MMC}[1-800-206-8125] {or for MLTC} [1-866-712-7197].

You can call [PLAN NAME] at [1-800-MCO-PLAN] if you have any questions about this notice.

Sincerely,

MCO/UR agent Representative

Enclosure: Complaint Appeal Request Form

{*Insert as applicable*}
[cc: Enrollee Representative(s)]

[PLAN NAME]
COMPLAINT APPEAL REQUEST FORM

Mail this form to:
[Plan Name]
[Address]
[City, State Zip]

Fax to: [Fax number]

Today's date: _____

Deadline: You must ask for a Complaint Appeal within 60 working days of receiving our response to your complaint.

Enrollee Information
Name: [First Name] [Last Name]
Enrollee ID: [Enrollee ID]
Address: [Address] [City, State Zip]
Home Phone: [Home Phone] Cell Phone: [Cell Phone]
Plan Reference Number: [Reference Number]

I think this response is wrong because:

_____

_____

_____

_____

_____

Check all that apply:

☐ I enclosed additional information to support my Complaint Appeal.

☐ I would like to give information in person.

☐ I want someone to ask for a Complaint Appeal for me:

- Have you authorized this person with [Plan Name] before? YES ☐ NO ☐
- Do you want this person to act for you for all steps of the appeal about this decision? You can let us know if change your mind. YES ☐ NO ☐

Requester (person asking for me)

Name: _____ E- mail: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone #: (_____)_____ Fax #: (_____)_____

Enrollee Signature: _____ Date:_____

Requester Signature:_____ Date:_____

If this form cannot be signed, the plan will follow up with the enrollee to confirm intent to appeal.

NOTICE OF NON-DISCRIMINATION

[PLAN NAME] complies with Federal civil rights laws. **[PLAN NAME]** does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

[PLAN NAME] provides the following:

- Free aids and services to people with disabilities to help you communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)

- Free language services to people whose first language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call **[PLAN NAME]** at <toll free number>. For TTY/TDD services, call <TTY>.

If you believe that **[PLAN NAME]** has not given you these services or treated you differently because of race, color, national origin, age, disability, or sex, you can file a grievance with **[PLAN NAME]** by:

Mail:	[ADDRESS], [CITY], [STATE] [ZIP CODE],
Phone:	[PHONE NUMBER] (for TTY/TDD services, call <TTY>)
Fax:	[FAX NUMBER]
In person:	[ADDRESS], [CITY], [STATE] [ZIP CODE]
Email:	[EMAIL ADDRESS]

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by:

Web:	Office for Civil Rights Complaint Portal at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*
Mail:	U.S. Department of Health and Human Services 200 Independence Avenue SW., Room 509F, HHH Building Washington, DC 20201 Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html
Phone:	1-800-368-1019 (TTY/TDD 800-537-7697)

ATTENTION: Language assistance services, free of charge, are available to you. Call <toll free number> <TTY/TDD> .	English
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al <toll free number> <TTY/TDD>.	Spanish
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 <toll free number> <TTY/TDD>.	Chinese
لحوظة: إذاكنتتحدثاللغةفإنخدماتالمساعدةاللغويةتتوافرلكمجان. اتصلبرقم TTY/TDD> رقم هاتفالصمموالبكمtoll free number	Arabic
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다<toll free number> <TTY/TDD> 번으로 전화해 주십시오.	Korean
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните <toll free number> (телетайп: TTY/TDD).	Russian
ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero <toll free number> <TTY/TDD>.	Italian
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le <toll free number> <TTY/TDD>.	French
ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele <toll free number> <TTY/TDD>.	French Creole
אויפמערקזאם: אויב איר רעדט אידיש, זענען פארהאן פאר אייך שפראך הילף סערוויסעס פריי פון אפצאל. רופט <toll free number/TTY/TDD.	Yiddish
UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer <toll free number> <TTY/TDD>	Polish
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa <toll free number/TTY/TDD>.	Tagalog
লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-<toll free number> <TTY/TDD>	Bengali
KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në <toll free number> <TTY/TDD>.	Albanian
ΠΡΟΣΟΧΗ: Αν μιλάτε ελληνικά, στη διάθεσή σας βρίσκονται υπηρεσίες γλωσσικής υποστήριξης, οι οποίες παρέχονται δωρεάν. Καλέστε <toll free number> <TTY/TDD>.	Greek
خبردار: اگر آپ اردو بولتے ہیں تو آپکو زبان کی مدد خدمات مفت میں دستیاب ہیں کال کریں <TTY <toll free number>.	Urdu