**THIS IS NOT A BILL**

**Important: Denial of payment for service**This is not a bill. We have denied a request from your provider to pay for a service or treatment. Please call us right away at <<###-###-### or TTY ###>> if you do not understand this letter. You can get this letter in large print, another language or any way that is best for you. You can ask for help from an interpreter. Help is free.

<<~~MCE~~CCO Letterhead

required in at least 12 pt font
(include name, address
phone number; add
subcontractor if applicable)>>

<< Date of Notice>>

<<MEMBER NAME

ADDRESS

CITY, STATE ZIP>>

OHP Client ID:<<OHP Client ID>>

Date of Birth: <<DOB >>

PCP/PCD/BHP:<< Member’s PCP/PCD/BHP/CLINIC/NOT YET ASSIGNED >>

**Reason for Payment Denial**(Also called Notice of Adverse Benefit Determination)

Dear <<Member name>>,

This is not a bill. You do not need to do anything. We have to send this to you so you have the information.

We were asked to pay for a service you received. We are not able to pay for it. This letter says why the request was not approved and what you can do next.

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| **Date decision is effective:** | <<Effective date>> |
| **Service payment was requested for:** | <<Rx/Procedure/Service Name in plain language and procedure codes>> |
| **Date of service:** | <<date of service>> |
| **Rendering Provider or facility name:** | <<Name of rendering/ performing/ billing provider/facility>> |
| **Service was to help treat:** | <<Diagnosis codes and description of diagnosis in plain language>> |
| **Reason for payment denial:**  | <<Reason for denial. If denial is for member covered under EPSDT, indicate results of review for medical necessity & medical/dental appropriateness review >>. <<Member specific info in plain language, related to criteria that was not met. This is why we were unable to pay for the service. The Oregon Health Plan (OHP) does not cover all services and supplies.>> |
| **Claim number:** | <<claim number, date if different than service date>> |
| **We based our decision on:** | <<List of all applicable OARs, Guideline Notes, HERC Clinical Guidance, medical policies or criteria, etc. OARs are listed with only the specific sections and subsections that apply to this member-specific decision.>> |

<<**We looked at other medical issues** When we looked at your records, we checked to see if you have a different medical issue that would let us cover this. There are rules we have to meet in order to do this. We had a health care professional review your case to see if you met those rules. Unfortunately, you did not meet those rules.>>

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<<**We did not look at other medical issues**
You may have other medical issues that would let us cover this service. There are rules we have to meet in order to do this. Your provider can ask us to review your case to see if you meet those rules.>>

**Did you get a bill? Call us right away.**If you get a bill for this service, call our Customer Service at <<XXX-XXX-XXXX / the number listed *below*>>. Do not pay the bill until you talk to us. We will see why you got a bill.

Providers should not bill you if a service is covered. If a service is not covered and you signed a valid Oregon Health Plan Agreement to Pay for Health Services form, you have to pay for it. You can see the waiver form at <https://bit.ly/OHPwaiver>. If you do not know if you signed a waiver form, ask your provider’s office.

You can ask us to change our decision.
If you disagree with our decision, you have the right to ask us to change it. We will resolve your appeal as quickly as your health requires.

To support your appeal, you have the right to:

* Give information and testimony in person or in writing.
* Make legal and factual arguments in person or in writing.

You must do these things within appeal timeframes listed below.

We have 16 days to reply. Need a faster reply? Ask for a fast appeal.

**Wait for our reply**

You must ask within 60 days of this letter’s date. Call us or send a form.

**Ask for an appeal**

Still don’t agree? You can ask the state to review. This is called a hearing.

**Read our decision**

You must ask within 120 days of the appeal decision letter date.

**Ask for a hearing**

Don’t agree with our decision?

Follow these steps:

**1**

**2**

**3**

**4**

**Appeals** -Call us at:
<<XXX-XXX-XXXX (TTY 711)>>
 **Hearings** - Call the state at:
800-273-0557 (TTY 711)

**Use the request form**
Scan the QR code to
get the form. Or go to <https://bit.ly/request2review>

**More about appeals and hearings**

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| **How much time do I have?** | You have 60 days to ask for an appeal. We must get your request within 60 days of <<Date of Notice>>. |
| **How can I ask for an appeal?** | Contact us by phone, letter, or fax. * Call us at <<XXX-XXX-XXXX>>
* Use the Request to Review a Health Care Decision form. The form was sent with this letter. You can also get it at <https://bit.ly/request2review>
* You can also fax us as <<XXX-XXX-XXXX>>.
* You can mail your request to us at <<address / the address at the top of the letter>>
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| **How long do you get to review my appeal?** | We get 16 calendar days to send you a reply. This is a normal appeal.If we need more time, we will call you and send you a letter within 2 days. We can delay our review up to 14 more days. This is also called an extension. |
| **What if I need a faster reply?** | You can ask for a fast appeal if waiting for the regular appeal could put your life, health or ability to function in danger. Fast appeals are for services you did not get yet. If you already got the service, a fast appeal request will not be approved.  |
| **What if I don’t agree with the delay or if you don’t meet the timelines above?** | If you do not agree with the delay, you can file a grievance or complaint. Call us at <<XXX-XXX-XXXX>> to file a complaint.If we don’t meet the timelines, you can ask the state for a review. This is called a hearing.  |
| **Who can ask for an appeal?**  | You or someone with written permission to speak for you. That could be your doctor or an authorized representative. |
| **How do I ask for a hearing?** | You have to ask for an appeal before you can ask for a hearing. If you do not agree with the appeal decision, ask the state to review it. The review is called a hearing. Choose one of these ways to ask for a hearing:* Submit a request online at <https://bit.ly/ohp-hearing-form>
* Use the request form that was sent with this letter or you can print the request form at <https://bit.ly/request2review>
* Call the state at 800-273-0557 (TTY 711)
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| **How much time do I have to ask for a hearing?** | You must ask for a hearing within 120 days of the date of the appeal decision letter. The letter is called a Notice of Appeal Resolution.  |
| **What if I need a faster hearing?** | Fast hearings are for services you did not get yet. If you already got the service, a fast hearing request will not be approved. |
| **Who can ask for a hearing?** | You or someone with written permission to speak for you. That could be your doctor or an authorized representative.  |

Other things you can do

* You can ask your doctor about other ways to treat your condition.
* You can ask us for the information used to make this decision.

 These things will **not** give you more time to ask for an appeal or hearing, so you will need to do them right away.

In the middle of treatment?
If you have been getting this service and we stopped providing it, you, ~~your provider~~ or your authorized representative, with your written permission, can ask us to continue it.

You need to ask for this within 10 days of the date of this letter or by the date this decision is effective, whichever is later.

* You can ask by phone, letter, or fax.
* You can also use the enclosed *Request to Review a Health Care Decision* form. Please answer “yes” to the question about continuing services in box 8 on page 4 of the form.

**Payment for this service**If you choose to still get this service, you may have to pay for it. If we change our decision during the appeal, or if the judge agrees with you at the hearing, you will not have to pay.

Get help

You can ask us for free copies of all paperwork used to make this decision.

If you need help or have questions, please call Customer Service at <<XXX-XXX-XXXX or TTY>>, Monday to Friday, 8 a.m. - 5 p.m.

All members have a right to know about and use our programs and services. We give these kinds of free help:

* Sign language interpreters
* Spoken language interpreters
* Materials in other languages
* Braille, large print, audio, and any way that works better for you

For information on certified Health Care Interpreters call <<XXX-XXX-XXXX or TTY>>.

CC: <<Rendering/Billing Provider Name>> <<Authorized Representative(if applicable)>>

Enclosures:

* Non-Discrimination Policy (Optional)
* Request to review a health care decision (OHP 3302)

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| English |
| You can get this letter in other languages, large print, Braille or a format you prefer. You can also ask for an interpreter. This help is free. Call <<CustomerService>> or TTY <<TTY>>. We accept relay calls. |
| Spanish |
| Puede obtener este documento en otros idiomas, en letra grande, braille o en un formato que usted prefiera. También puede recibir los servicios de un intérprete. Esta ayuda es gratuita. Llame al servicio de atención al cliente <<CustomerService>> or TTY <<TTY>>. Aceptamos todas las llamadas de retransmisión.  |
| Russian |
| Вы можете получить это письмо на другом языке, напечатанное крупным шрифтом, шрифтом Брайля или в предпочитаемом вами формате. Вы также можете запросить услуги переводчика. Эта помощь предоставляется бесплатно. Звоните по тел. <<CustomerService>>или TTY <<TTY>>. Мы принимаем звонки по линии трансляционной связи. |
| Vietnamese |
| Quý vị có thể nhận tài liệu này bằng một ngôn ngữ khác, theo định dạng chữ in lớn, chữ nổi Braille hoặc một định dạng khác theo ý muốn. Quý vị cũng có thể yêu cầu được thông dịch viên hỗ trợ. Sự trợ giúp này là miễn phí. Gọi <<CustomerService >> hoặc TTY (Đường dây Dành cho Người Khiếm thính hoặc Khuyết tật về Phát âm) <<TTY>>. Chúng tôi chấp nhận các cuộc gọi chuyển tiếp. |
| Arabic |
| يمكنكم الحصول على هذا الخطاب بلغات أخرى، أو مطبوعة بخط كبير، أو مطبوعة على طريقة برايل أو حسب الصيغة المفضّلة لديكم. كما يمكنكم طلب مترجم شفهي. إن هذه المساعدة مجانية. اتصلو على <<CustomerService>> أو المبرقة الكاتبة <<TTY>>. نستقبل المكالمات المحولة. |
| Somali |
| Waxaad heli kartaa warqadan oo ku qoran luqaddo kale, far waaweyn, farta dadka indhaha aan qabin wax ku akhriyaan ee Braille ama qaabka aad doorbidayso. Waxaad sidoo kale codsan kartaa turjubaan. Taageeradani waa lacag la’aan. Wac <<CustomerService>> ama TTY <<TTY>>. Waa aqbalnaa wicitaanada gudbinta. |
| Simplified Chinese |
| 您可获取本文件的其他语言版、大字版、盲文版或您偏好的格式版本。您还可要求提供口译员服务。本帮助免费。致电<<Customer Service>> 或TTY <<TTY>>。我们会接听所有的转接来电。 |
| Traditional Chinese |
| 您可獲得本信函的其他語言版本、大字版、盲文版或您偏好的格式。您也可申請口譯員。以上協助均為免費。請致電<<CustomerService>> 或聽障專線<<TTY>>。我們接受所有傳譯電話。 |
| Korean |
| 이문서은 다른 언어, 큰 활자, 점자 또는 선호하는 형식으로 받아보실 수 있습니다. 통역사를 요청하실 수도 있습니다. 무료 지원해 드립니다. <<555-555-5555>> 또는 TTY <<TTY>>에 전화하십시오. 저희는 중계 전화를 받습니다.  |
| Chuukese |
| En mi tongeni angei ei taropwe non pwan ew fosun fenu, mese watte mak, Braille ika pwan ew format ke mwochen. En mi tongeni pwan tingor emon chon chiaku Ei aninis ese fokkun pwan kamo. Kokori <<555-555-5555>> ika TTY <<TTY>>. Kich mi etiwa ekkewe keken relay. |
| Ukrainian |
| Ви можете отримати цей довідник іншими мовами, крупним шрифтом, шрифтом Брайля або у форматі, якому ви надаєте перевагу. Ви також можете попросити надати послуги перекладача. Ця допомога є безкоштовною. Дзвоніть по номеру телефону <<555-555-5555>> або телетайпу <<TTY>>. Ми приймаємо всі дзвінки, які на нас переводять. |
| Farsi |
| می‌توانید این نامه را به زبان‌های دیگر، درشت‌خط، بریل یا قالب ترجیحی دیگری دریافت کنید. می‌توانید مترجم شفاهی نیز درخواست کنید. این کمک رایگان است. با <<CustomerService>> یا <<TTY >>TTY تماس بگیرید. تماس‌های رله را می‌پذیریم. |
| Swahili |
| Unaweza kupata herufi hii kwa lugha zingine, kwa herufi kubwa, kwa lugha ya maandishi kwa vipofu au namna yeyote unayopendelea. Unaweza pia kuomba mkalimani. Msaada huu ni wa bure. Piga <<CustomerService>> au TTY <<TTY>>. Tunakubali simu za kupitisha ujumbe. |
| Burmese |
| ဤစာကို အျခားဘာသာစကားမ်ား၊ ပုံႏွိပ္စာလုံးၾကီး၊ မ်က္မျမင္မ်ားအတြက္ ဘေရးလ္ သို႔မဟုတ္ သင္ပိုမိုႏွစ္သက္သည့္ ပုံစံျဖင့္ ရယူနိုင္ပါသည္။ သင္သည္ စကားျပန္တစ္ဦးလည္း ေတာင္းဆိုနိုင္ပါသည္။ ဤအကူအညီသည္ အခမဲ့ျဖစ္ပါသည္။ <<CustomerService>> သို႔မဟုတ္ <<TTY>> ကို ဖုန္းဆက္ပါ။ ထပ္ဆင့္ေခၚဆိုမႈမ်ားကို ကၽြႏ္ုပ္တို႔ လက္ခံပါသည္။ |
| Amharic |
| ይህንን ደብዳቤ በሌሎች ቋንቋዎች፣ በትልቅ ህትመት፣ በብሬይል ወይም እርሶ በሚመርጡት መልኩ ማግኘት ይችላሉ። በተጨማሪም አስተርጓሚ መጠየቅም ይችላሉ። ይህ ድጋፍ የሚሰጠው በነጻ ነው። ወደ <<CustomerService>> ወይም TTY <<TTY>> ይደውሉ። የሪሌይ ጥሪዎችን እንቀበላለን። |
| Romanian |
| Puteți obține această scrisoare în alte limbi, cu scris cu litere majuscule, în Braille sau într-un format preferat. De asemenea, puteți solicita un interpret. Aceste servicii de asistență sunt gratuite. Sunați la <<CustomerService>> sau TTY <<TTY>>. Acceptăm apeluri adaptate persoanelor surdomute. |