[FIDA-IDD PLAN NAME/LOGO]

**Appeal Level:** **1**

appeal level 1 figure

**Acknowledgment of Appeal**

**Name: Date of Notice:**

**Participant Number:**

[*Insert other identifying information, as necessary (e.g., provider name, Participant’s Medicaid number, service subject to notice, date of service)*]

Dear <Participant name>,

On <date appeal received, orally or in writing> [*for expedited appeals insert:* at <hour received>] you, or someone acting for you, appealed the following action: [*Insert a brief description of the FIDA-IDD Plan action/IDT decision (e.g. denial, reduction, Life Plan renewal, etc.) being appealed and the benefits involved.*]

[*Insert if (1) the action involves a stoppage, reduction, or restriction on a previously authorized benefit, and (2) the appeal was received within 10 days of the ICDN postmark date or before the date the action was intended to take effect, whichever is later:* You will continue to get the disputed service while your appeal is processing.]

**<Plan name> contact information**

You can contact <plan name> with questions about your appeal or this notice using the following contact information:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

**Appeal review process**

This is Level 1 of the appeal process. <Plan name> is reviewing the appeal requested for the action described above. No persons assigned to review your appeal were involved in the original action. We will mail a notice to you and your representative (if you have one) when we make a decision. The notice will explain our decision and what you can do if you disagree.

We will make a decision about your appeal by [*Insert date/time of appeal decision deadline (72 hours from receipt of appeal for fast appeals, 7 calendar days from receipt of appeal for standard Medicaid prescription drug appeals or for a Medicare Part B prescription drug, 60 calendar days from receipt of appeal for reimbursement requests, and 30 calendar days from receipt of appeal for all other standard appeals)*]. [*Insert for expedited appeals:* We will try to contact you in person or by phone as soon as we decide your appeal.]

If you would like extra time to submit information to support your appeal, you can ask us to delay our decision by up to 14 more calendar days. Or, if we need to gather more information to decide your appeal, we can take up to 14 more calendar days to make our decision. If we take extra time, we will notify you in writing. We can’t take extra time to make a decision if your appeal is for a Medicare Part B prescription drug. If you believe we should not take more time to make a decision, you can file a fast grievance. We will respond to your grievance in 24 hours.

[*Insert the following section if plan denied request for a fast appeal:*]

**Denial of request for a fast appeal**

We denied your request for a fast appeal. If you think we made a mistake, you can file a fast grievance. For more information, please refer to the enclosed notice titled “We Cannot Give You a Fast (or “Expedited”) Appeal.”

**Request an in-person or phone-based review**

Our review of your appeal will occur at our office by staff who were not involved in the original decision. These individuals will review the documents we have and any that you submitted or that were submitted for you, and they will make a decision on your appeal. This is called a desk review.

You are, however, entitled to a reasonable opportunity to present your case in-person or by phone if you do not want a desk review. If you asked for an in-person or phone-based review, we will arrange a time (and location) with you or your representative (if you have one) and send a notice by mail to confirm. If you would like to have an in-person or phone-based review and have not yet asked for one, you can do so by calling us at: <phone number>. TTY users call <TTY number>.

**Transportation to in-person review**

If you ask for an in-person review, you, and any witnesses that may require it, are entitled to receive necessary transportation to and from the in-person review. If you are homebound, or if transportation could be harmful to your health or safety, make sure to ask that the in-person review is conducted at your home or other residence.

<Plan name> will only provide transportation or an at-home review when necessary. It is important for you or your representative to give <plan name> an explanation for why transportation services or an at-home review is needed. You can ask for transportation services by calling us at: <phone number>. TTY users call <TTY number>.

**Getting your case file and submitting evidence**

You have the right to get a copy of any documents from your case file with <plan name> that will help you show why our decision was wrong. You or your representative (if you have one) may ask for these documents, at no cost, by calling <phone number> or by fax to <fax number>.

If you would like us to consider any evidence or testimony before we make our decision, you should submit it **as soon as possible**. You may also present evidence or testimony at an in-person or phone-based review, if requested. You can submit evidence or testimony **(1)** over the phone, **(2)** by mail or fax, [or] **(3)** at your in-person review [*Insert if the plan has a drop-off location:* , or **(4)** by hand delivery at our drop-off location before your review]. We recommend keeping a copy of everything for your records. Please submit evidence or testimony to:

**<Plan name>**

<Name of Appeals/Grievance Department>

<Mailing Address for Appeals/Grievance Department>

<Drop-off Address, if applicable>

Phone: <phone number> TTY: <TTY number>

Fax: <fax number>

**If you want someone to represent you**

You can have someone else represent you during your appeal. You can choose anyone to represent you, like a family member, friend, doctor, attorney.

If you already named someone to represent you when you asked for this appeal, or if you have someone who is otherwise able to act for you because they are a legal guardian, power of attorney, or otherwise authorized to make health care decisions on your behalf, you do not have to do anything else.

If you have not already named someone to represent you and want to choose someone now, both you and the person you want to act for you must sign and date a statement confirming this is what you want. You can write a letter or use the Appointment of Representative form available at [www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf](https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf). Send your letter or form to us by fax or mail, or give it to your Care Manager. Keep a copy for your records. If you have any questions about naming your representative, such as what to say in your letter, call us at: <phone number>. TTY users call <TTY number>.

The state created the **Independent Consumer Advocacy Network (ICAN)** to help you with appeals and other issues with the FIDA-IDD program. ICAN is independent, and the services are available to you for free. They can help answer your questions about the appeals process, give you advice. Call ICAN at 1-844-614-8800. TTY users call 711, then follow the prompts to dial 844-614-8800.

[*The plan must send a copy of this notice to relevant parties (e.g. representative, designated caregiver, etc.) and include the following text:*]

A copy of this notice has been sent to: <name>

<address>

<phone number>

**Get help & more information**

(TTY users call 711, then use the phone numbers below)

| * <Plan name>   Website: <plan website>  Toll Free Phone: <phone number>  TTY users call: <TTY number>  <days and hours of operation>   * Independent Consumer Advocacy Network (ICAN)   633 Third Ave, 10th Floor  New York, NY 10017  Website: [icannys.org](http://icannys.org/)  Email: [ICAN@cssny.org](mailto:ICAN@cssny.org)  Toll Free Phone: 1-844-614-8800  8:00am – 8:00pm, Monday – Sunday   * Medicare Rights Center   Toll Free Phone: 1-800-333-4114 | * 1-800-MEDICARE (1-800-633-4227)   TTY users call: 1-877-486-2048  24 hours a day, 7 days a week   * NYS Department of Health   Bureau of Managed Long Term Care  Toll Free Phone: 1-866-712-7197   * NYS Office for People With Developmental Disabilities (OPWDD)   Toll Free Phone: 1-866-946-9733  Community Health Access to Addiction and Mental Healthcare Project (CHAMP)  633 Third Ave, 10th Floor  New York, NY 10017  Website: [www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ](http://www.cssny.org/programs/entry/community-health-access-to-addiction-and-mental-healthcare-project-champ)  Email: [ombuds@oasas.ny.gov](mailto:ombuds@oasas.ny.gov)  Phone: 1-888-614-5400 (TTY Relay Service: 711) |
| --- | --- |

[*Plan must include all applicable disclaimers as required in the State-specific Marketing Guidance*.]

You can get this document for free in other formats, such as large print, braille, or audio. Call [*insert Participant Services toll-free phone and TTY numbers and days and hours of operation*]. The call is free.