CONFIDENTIAL

Attachment 6

[Insert Logo Here]	**Address** **City, State, Zip** **Telephone** **(TTY/TDD)**

NOTICE OF APPEAL DECISION

{Date}

{Participant's / Representative's Name}
{c/o Participant}
{Address}

Re: Notice of Decision on Your [Standard or Expedited] Appeal

Mr/s. {Name}:

This letter is to notify you of the decision made on your appeal you filed with [PACE Program] on [insert date] related to [insert brief description of appeal].

After careful review and evaluation of your appeal by a qualified, independent reviewer, {PACE program} has upheld its original decision to [deny / delay / modify / deny payment] for [requested service], based on the following:

_____
_____
_____
_____

If you are not satisfied with this decision or we failed to provide you with a decision within the required timeframe for a standard or expedited appeal, you have the right to pursue an external appeal through Medi-Cal or Medicare, as described in the enclosed "*Information for Participants about Appeals Process*" under "Additional Appeal Rights under Medi-Cal and Medicare". If you have both Medicare and Medi-Cal and you are not sure with which external program to file your appeal, we will assist you in choosing one if both are applicable. We will also assist you in preparing the appeal and forward it to the appropriate external program.

Please note that if you are enrolled in Medi-Cal and you choose to continue the service during the external review process, {PACE Program} will *not* discontinue the service for which an external appeal has been filed until the external appeal process has concluded. However, if {PACE Program's} initial decision to discontinue or reduce a service is upheld or is not in your favor, you may be financially responsible for the cost of the disputed service provided during the external appeal process.

If you wish to pursue your appeal for an external review, please contact [our Quality Assurance Department] for assistance at [telephone number] or [mailing address]. For

the hearing impaired (TTY/TDD), please call [insert number]. Please note that DHCS treats all participant information included in the appeal process as confidential.

Thank you for your involvement in this process.

Sincerely,
[Medical Director] OR
[Program Director]

Enclosures

cc: [Integrated Systems of Care Division, Assigned Contract Manager]
[Centers for Medicare and Medicaid Services, Assigned Account Manager]
[Treating Provider (if applicable)]