**IF YOU DO NOT AGREE WITH THIS DECISION, YOU HAVE A RIGHT TO APPEAL IT**

**You have 60 days from the date of this Notice to ask for an Appeal.**

After 60 days, the decision in this Notice is final. Follow these instructions to ask [LME NAME] for an Appeal.

**It is easy to ask for an Appeal.** Use one of the options below.

* **MAIL:** Fill out and sign the Appeal Request Form in this Notice. Mail it to the address listed on the form.
* **FAX:** Fill out and sign the Appeal Request Form in this Notice. The fax number is on the form.
* **BY PHONE:** Call us at [PHONE NUMBER] and ask for an Appeal. You will still need to send us your Appeal Request Form after you call.
* **IN-PERSON:** You can bring your completed Appeal Request Form to us at [ADDRESS].

**What happens when you fax, mail or hand deliver your Appeal Request Form to our office?**

[LME NAME]must receive your Appeal Request Form by [60TH DAY AFTER DATE OF NOTICE MAILED]. The decision in this Notice becomes final after this date. We will send you a letter letting you know we got your Appeal Request Form. We must give you a decision on your Appeal within 30 calendar days.

**What happens when you call us to ask for an Appeal?**

[LME NAME] must always receive your phone call by [60TH DAY AFTER DATE OF NOTICE MAILED]. **You must still send us your completed Appeal Request Form**. Some special rules apply when you call us. Please read them below:

1. When you send your Form by the 14th day after you call us, we will finish your appeal within 30 days of your call.
2. When you send your Form later than the 14th day after you call us **and** your time to file an appeal has not ended, we will finish you appeal within 30 days after we receive your Form.
3. If you do not send us your Form within 14 days of your call **and** your time to file an appeal has ended, your appeal will not be accepted.

You can give us any new information, including new medical documents from your provider, that you think will help us approve your request.  You may do that in-person, in writing or by phone.

**EXPEDITED APPEALS**

If you need a quick decision because your life, your physical or mental health, or your ability to attain, maintain or regain maximum function is in danger, you can ask for an “expedited (faster) appeal”. To ask for an expedited appeal, call [PHONE NUMBER]. You can also fax your request for an expedited appeal. Instructions are on your Appeal Request Form. **If you call to ask for an expedited appeal, you do not need to send us your Appeal Request Form after you call.**

When your health care provider asks us for a faster decision, we will decide your appeal within 72 hours of the request. When you ask us directly for a faster decision, we must make sure your health condition qualifies you for an expedited appeal. After you qualify, we will decide your appeal within 72 hours of your request. If you do not qualify, we will finish your appeal within 30 days. You have until [60th DAY AFTER NOTICE MAILED] to ask us for an expedited appeal. If we deny your request for an Expedited Appeal, we will call you during our business hours promptly following our decision. We will also mail you a written Notice within two days. You may file a formal grievance with us if you do not agree with our decision to deny you a faster appeal. To file a grievance, call [PHONE NUMBER].

**YOU WILL RECEIVE ANY SERVICES WE APPROVED IN OUR DECISION, EVEN WHEN YOU APPEAL**

You will receive any services we approved in the request you made on [DATE OF REQUEST]. You can always ask for more services while we finish your Appeal.

**[LME NAME] MUST PAY FOR THE SERVICES WE APPROVE IN YOUR APPEAL**

 [LME NAME] may change the decision in this Notice because of your appeal. This means that we may decide to approve the services you asked for. When this happens, we will pay for these services beginning from the date of our original decision as long as you properly document that the services were provided pending the appeal. This date is on the first page of this Notice.

**YOU MAY ASK SOMEONE TO HELP YOU WITH YOUR APPEAL**

You may ask someone to help you with your Appeal. You may choose anyone to help, including a friend, a relative, your provider or a lawyer. **You must give them your written permission.** Include their name and contact information on the Appeal Request Form. You may name someone to help you after you send your form, but you must still give your permission in writing.

**ASKING FOR AN EXTENSION (MORE TIME) TO PREPARE YOUR APPEAL**

If you need more time to get ready, you may call [PHONE NUMBER] to ask for an extension. [LME NAME] **must** finish your appeal within 30 days of the day we get your request.  **We may only take more time if it will help us to approve your request.** If we need more time, we will inform you by mail. The letter will tell you what to do if you do not agree with our request.

**YOUR REVIEWER WILL BE PROFESSIONAL, IMPARTIAL AND FAIR**

A healthcare professional with clinical expertise in treating your condition or disease will decide your appeal. Your reviewer did not make the decision found in this Notice. Also, your reviewer is not supervised by anyone who was involved in making this decision.

**YOUR RIGHT TO ASK FOR A STATE FAIR HEARING (STATE APPEAL)**

We will send you a Notice of Decision when we finish your Appeal. If you do not agree with our decision, you can ask for a State Fair Hearing. You can ask for a State Fair Hearing without waiting any longer whenever we are unable to finish your appeal on time, or if we do not send you a Notice of our decision. You will receive all instructions and forms you will need to request a State Fair Hearing in the same letter as your Notice of Decision.

You can also learn more about the North Carolina Medicaid Fair Hearing process at:

* NC Medicaid: “Your Due Process Rights”: [www.medicaid.ncdhhs.gov/medicaid/your-rights](http://www.medicaid.ncdhhs.gov/medicaid/your-rights)
* NC Office of Administrative Hearings: [www.oah.nc.gov/hearings-division/medicaid-recipient-appeals](file:///%5C%5C10.52.235.160%5CShared%5CAllUsers%5CErin%20Elsworth%5C_Letter%20Templates%5CLME%5C_LME%20Initial%20Notice%202001%20%26%202002%5CLME%20Initial%20Decision%20Letter%20Components%5Cwww.oah.nc.gov%5Chearings-division%5Cmedicaid-recipient-appeals)

**DO YOU HAVE QUESTIONS OR NEED HELP?**

Call [LME NAME] at [PHONE NUMBER] during normal business hours: [INSERT BUSINESS HOURS HERE]

We can answer questions about your appeal, help you to fill out your paperwork or get you a copy of your Notice and your Appeal Request Form.

**FREE LEGAL AID MAY BE ABLE TO ASSIST WHEN YOU APPEAL A DECISION**

* Contact your nearest **Legal Aid of North Carolina** office. If you need the telephone number of the office serving your community, call 1-866-219-5262 (toll-free).
* If the member is a person with a disability, you may also contact **Disability Rights of North Carolina** toll-free at 1-877-235-4210, or at 1-919-856-2195.

You may contact your NC Medicaid Offices by calling the **Medicaid Contact Center** at **1-888-245-0179**, Monday-Friday 8 a.m. -5 p.m. Eastern time