**DECISION ON YOUR REQUEST FOR SERVICES**

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| **Notice Date:** [DATE] | *Space intentionally blank* | **PA #:** [PA NUMBER] |
| **This Action will take effect on:** [EFFECTIVE DATE] | **Call** [LME HELP LINE] **for help** |
| [BENEFICIARY OR LEGAL GUARDIAN][ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] | [REQUESTOR NAME][ADDRESS LINE 1][ADDRESS LINE 2][CITY, STATE, ZIP] |
| **MID:** [BENEFICIARY MID] | **DOB:** [BENEFICIARY DOB] | **Beneficiary:** [BENEFICIARY NAME] |
| [LME/MCO] manages Medicaid behavioral health services in [NAME OF BENEFICIARY COUNTY]. On [DATE OF REQUEST], you or your provider asked us to approve your request for behavioral health services.  |
| Choose an item. |
| **IF YOU DO NOT AGREE WITH OUR DECISION, YOU CAN APPEAL IT.**This letter tells you about our decision. Please read it carefully.You can ask for an Appeal by mail, by fax, by phone, or in-person. There are instructions in this Notice that will tell you what to do. Please read them carefully. The last day to ask for an Appeal is [DATE]. You have 60 calendar days from the date on this Notice to ask for an Appeal. If the 60th day is a weekend or holiday you have until the next business day. If you need help filing your appeal, call us at [PHONE NUMBER]. |

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| **YOU ASKED FOR:** |
| **Service Description**  | **Code 1** | **Code 2** | **Plan** | **Requested Dates** | **Requested Amount** |
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| **WE APPROVED:** |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Approved Dates** | **Approved Amount**  |
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|  |  |  |  |  |  |
| **WE DENIED:** |
| **Service Description** | **Code 1** | **Code 2** | **Plan** | **Denied Dates**  | **Denied Amount** |
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|  |  |  |  |  |  |
| **COMMENTS**: [LME DEFINED FREE TEXT AVAILABLE]  |
| DD 1: **We asked your provider to send us more information to help us approve your request. Your provider did not send us the information.*** On [DATE OF REQUEST FOR ADDITIONAL INFORMATION], we asked your provider for the following important facts or documents:

[FREE TEXT STATEMENT ON ADDITIONAL INFORMATION REQUESTED]. * Without this additional information, your request did not meet criteria for approval found in [IDENTIFY POLICY HERE].
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| DD 2: **We denied your request for:** * [CODE] [SERVICE DESCRIPTION]:

**Policy rules found at [STATE SECTION AND POLICY NAME HERE] guided our decision.** Here are the specific policy requirements your request did not meet:[POLICY CITATION IN FREE TEXT] |
| DD 3: **We denied your request for:** * [CODE] [SERVICE DESCRIPTION]:

**Your provider did not send us information we requested.** * On [DATE OF REQUEST FOR ADDITIONAL INFORMATION], we asked your provider for the following important facts or documents:

[FREE TEXT STATEMENT ON ADDITIONAL INFORMATION REQUESTED]. * Without this additional information, your request did not meet criteria for approval found in [POLICY NAME HERE].
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| DD 4: **North Carolina Medicaid does not cover the following service(s) in our State Medicaid Plan:** [CODE] [SERVICE DESCRIPTION].  |
| **Authority Supporting Decision:**We base our decision to approve or deny a request for Medicaid services on:* Established Clinical Practice Guidelines, found on our website at: [LME WEBSITE HERE]
* Medicaid Clinical Coverage Policies found at: <https://medicaid.ncdhhs.gov/providers/clinical-coverage-policies>
* **10A NCAC 25A .0201: MEDICAL SERVICES** All medical services performed must be medically necessary and may not be experimental in nature. Medical necessity is determined by generally accepted North Carolina community practice standards as verified by independent Medicaid consultants.
* The North Carolina State Plan for Medical Assistance, found at: <https://medicaid.ncdhhs.gov/get-involved/nc-health-choice-state-plan>

If you want us to send you a free copy of these documents, please call [PHONE NUMBER]. We will mail the documents to you within five business days.  |
| **We can give you a free written copy of the full clinical rationale, rules or standards that we used and information we generated when we made this decision. If you want a free copy, call us at:** **[PHONE NUMBER].**You also have the right to see your entire case file. Your case file includes all your medical records, other documents and records. It may have more information about why your health care service was changed or not approved. To arrange to see your file, call [PHONE NUMBER]. If you say you want a copy of your entire case file, we will give you or your authorized representative a free copy before we finish your appeal.  |