

**NOTICE OF ADVERSE BENEFIT DETERMINATION**

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| **Date:**       | **CMH ID:** Consumer # |
| **Name:** Enter Consumer Name | **Medicaid ID Number:** Enter Medicaid ID # |
| **This is to tell you that the following action has been taken:**Enter the action taken |
| **The action is based on the following:**Supporting rationale for action |

You can share a copy of this decision with your provider so you and your provider can discuss next steps. If your provider asked for coverage on your behalf, we have sent a copy of this decision to your provider.

**If you don’t agree with our action, you have the right to an internal appeal**

You have to ask HealthWest for an internal appeal within 60 calendar days of the date of this notice. You, your representative, or your doctor can send in your request that must include:

* Your name
* Address
* Member number
* Reason for appealing
* Whether you want a standard or fast appeal (for an expedited or fast appeal, explain why you need one).
* Any evidence you want us to review, such as medical records, doctor’s letters or other information that explains why you need the item or service. If you are asking for a fast appeal you will need a doctor’s supporting statement. Call your doctor if you need this information.

Please keep a copy of everything you send us for your records.

**There are 2 kinds of internal appeals:**

**Standard Appeal** – We will give you a written decision on a standard appeal within **30 calendar** **days** after we receive your appeal. Our decision might take longer if you ask for an extension or if we need more information about your case. We will tell you if we are taking extra time and will explain why more time is needed. If your appeal is for payment of a service that you have already received, we will give you a written decision within **60 calendar days**. If you want to ask for an internal appeal, you can either call or send in a written request to:

**Lakeshore Regional Entity**

**5000 Hakes Drive #250**

**Norton Shores, MI 49441**

**1-800-897-3301**

**Expedited or Fast Appeal** – We will give you a decision on a fast appeal within **72 hours** after we receive your appeal. You can ask for a fast appeal if you or your doctor believe your health could be harmed by waiting up to 30 calendar days for a decision. **We will automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request**. If you ask for a fast appeal without support from a doctor, we will decide if your request requires a fast appeal. If we do not give you a fast appeal, we will give you a decision within 30 calendar days. To ask for a fast appeal, you must call: **1-800-897-3301, TTY Phone 711.**

**Continuation of services during an internal appeal**

If you are receiving a Michigan Medicaid service and you file your appeal within 10 calendar days of this Notice of Adverse Benefit Determination Click here to insert 10 day calendar date, you may continue to receive your same level of services while your internal appeal is pending. You have the right to request and receive benefits while the internal appeal is pending and should submit your request to HealthWest.

Your benefits for that service will continue if you request an internal appeal within **10 calendar days** from the date of this notice or from the intended effective date of the proposed adverse action whichever is later.

**If you want someone else to act for you**

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-800-897-3301 to learn how to name your representative. TTY users call 711. Both you and the person you selected to be your representative must sign and date a statement confirming this is what you want. You will need to mail or fax this statement to us. Keep a copy for your records.

**Access to Documents**

You and your authorized representative are entitled to reasonable access to and a free copy of all documents relevant to your appeal any time before or during the appeal. You must submit the request in writing.

**What happens next?**

* If you ask for an internal appeal and we continue to deny your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. If the service is covered by Michigan Medicaid, you can ask for a Medicaid State Fair Hearing.
* The Notice of Appeal Denial will give you additional information about the State Fair Hearings process [or Patient Right to Independent Review Act] including how to file the request.
* If you do not receive a notice or decision about your internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

**Get help & more information**

* Lakeshore Regional Entity: If you need help or additional information about our decision and the internal appeal process, call Member Services at: 1-800-897-3301 (TTY:711), Monday through Friday, 8:00 am to 5:00 pm. You can also visit our website at https://www.lsre.org.
* Michigan Department of Health and Human Services (MDHHS): Beneficiary Help Line; 1-800-642-3195. TTY users call 1-866-501-5656 or 1-800-975-7630 (if calling from an internet based phone service).

The legal basis for this decision is 42 CFR 440.230(d), Michigan's Mental Health Code, Public Act 258, and/or applicable policy found in the Medicaid Provider Manual, Mental Health and Substance Abuse Services. These provide the basic legal authority for us to place appropriate limits on a service based on such criteria as medical necessity or on utilization control procedures. Section 1557 of the Patient Protection and Affordable Care Act prohibits discrimination based on race, color, national origin, sex, age, or disability.

**Non-Discrimination and Accessibility Notice**

HealthWest complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. HealthWest does not exclude people or treat them differently because of race, color, national origin age, disability, or sex.

HealthWest provides free aids and services to people with disabilities to communicate effectively with us, such as:

* Qualified sign language interpreters.
* Written information in other formats (large print, audio, accessible electronic formats, other formats).
* Provides free language services to people whose primary language is not English, such as:

º Qualified interpreters

º Information written in other languages

If you need these services, contact Customer Service at 231-720-3201

If you believe HealthWest has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Customer Services Department:

**HealthWest**

**Customer Services Department**

**376 E Apple Avenue**

**Muskegon, MI 49442**

**231-720-3201**

**Customer.Services@HealthWest.net**

You can file a grievance by mail, fax or email. If you need help in filing a grievance, our Complaints and Grievance Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 1-800-368-1019, 800-537-7697 (TTD) Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.



