



# NOTICE OF ADVERSE BENEFIT DETERMINATION

**Important:** This notice explains your internal appeal rights. Read this notice carefully. If you need help with this notice or asking for an appeal, you can call one of the numbers listed on the last page under "Get help & more information."

**Date:** ACCMHS Member ID:  
**Name:** Beneficiary Medicaid ID:  
**Address:**

### This is to tell you that the following action has been taken:

*(Enter information regarding the adverse benefit determination taken to deny, reduce, suspend or terminate a covered benefit or payment with effective dates)*

### This action is based on the following:

*(Include citations with descriptions that are understandable to the member of applicable State and Federal rule, law, and regulation that support the action. You may also include Evidence of Coverage/Member Handbook provisions as well as Plan policies/procedures or assessment tools used to support the decision.)*

<b>This notice was provided to:</b>	<b>On this date:</b>
<b>Staff Signature and Credentials or Job Title:</b>	<b>Date:</b>

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 Appeal

You have to ask Beacon Health Options for an appeal within 60 calendar days of the date of this notice. You, your representative or your doctor {provider} 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, doctors' 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 appeals: Standard Appeal** – We'll give you a written decision on a standard appeal within **30 calendar days** after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We'll tell you if we're taking extra time and will explain why more time is needed. If your appeal is for payment of a service you've already received, we'll give you a written decision within **60 calendar days**. If you want to ask for an appeal, you can either call or send in a written request to:

**Beacon Health Options**  
**48561 Alpha Dr. Ste. 150, Wixom, MI 48393-3442**  
**1-800-897-3301**

**Expedited or Fast Appeal** – We'll give you a decision on a fast appeal within **72 hours** after we get 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'll 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'll decide if your request requires a fast appeal. If we don't give you a fast appeal, we'll 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 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 <insert 10 calendar day date>, you may continue to receive your same level of services while your appeal is pending. You have the right to request and receive benefits while the appeal is pending and should submit your request to Beacon Health Options. Your benefits for that service will continue if you request an 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 want to act for you must sign and date a statement confirming this is what you want. You'll 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 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 and how to file the request.
- If you do not receive a notice or decision about your appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Administrative Hearing System.

**Get help & more information**

- Beacon Health Options: If you need help or additional information about our decision and the appeal process, call Member Services at: 1-800-897-3301 (TTY: 711), Monday through Friday, 8am to 5pm. You can also visit our website at [www.beaconhealthoptions.com](http://www.beaconhealthoptions.com).
- 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).