[Instructions for Health Plan: (Do not include bracketed instructions in letters to members.)

Document Title: Appeal Resolution Letter Template (HMO Adverse Benefit Determination Reversed)

This notice is intended to notify members when the HMO has reversed the initial adverse benefit determination. (See Article I or 42 CFR 438.400 for definitions.) The notice of appeal resolution must be postmarked on or before the 30th calendar day after receiving the appeal, or the 44th calendar day if there has been an extension. (See Article IX or 42 CFR 438.408 for timelines.)

**How to use this notice template**

* Health plans may modify the format of this letter as needed to ensure readability and accessibility for members. However, all information must remain in the letter unless otherwise noted in these instructions.]

# **Your Appeal Decision**

<Mailing Date>

|  |  |
| --- | --- |
| <Member’s Name> | <Member MA ID Number> |
| <Member/Authorized Representative’s Address> |  |

Dear <First Name.> <Last Name>,

The <Health Plan Name> Grievance and Appeal Committee decided on your appeal about <insert service or benefit in question>. <You participated/You and your representative participated/Your representative participated/You chose not to participate> in the meeting on <date>. After reviewing your case, the <Health Plan Name> Grievance and Appeal Committee decided to <description of the decision>.

The reason for this decision is <Must include specific explanation for why the original decision was reversed>.

Thank you for using our appeals process. <Health Plan Name> care management staff will contact you within 72 hours to carry out this decision. If you have any follow-up questions, contact <Health Plan member advocate> at <telephone number>.

<Signature block>