**[DATE] [This MUST be the date the notice is Mailed]**

**[Member Name]**

**[Address]**

**[City, State Zip]**

**RE: [Member Identifiers, e.g., Name, DOB, ID#]**

**Subject**: Decision About Your Adverse Benefit Determination Appeal

Dear **[Member Name]**:

**This is an important notice about your services. Read it carefully.**

**Call [Insurer] at [Insurer Phone # & Toll-free TTY/PA RELAY] if you have any questions or need help.**

**[Insurer]** has reviewed your Adverse Benefit Determination about **[issue],** received on **[date]**.

Based on a review of all information provided, the Adverse Benefit Determination review committee has decided that **[state decision (uphold, partially uphold) in detail at a 6th grade reading level]**.

The reasons for this decision are**: [Explain at a 6th grade reading level in detail every reason for decision. In addition to explanation for decision, include specific references to approved medical necessity guidelines, rules, or protocols on which the decision is based in easily understood language. If denied because of insufficient information, identify all additional information needed to render decision.]**

Please see the following pages for your options to request an appeal of this decision by an independent review organization.

Sincerely.

[Insurer]

**We have [upheld / partially upheld] the denial of your request for the provision of or payment for a health care service or course of treatment.**

**What if I disagree with the decision?**

You may have the right to have our decision reviewed by health care providers who have no association with us if our decision involved making a judgment on the

* medical necessity
* appropriateness
* health care setting
* level of care
* effectiveness

of the health care service or treatment you requested.

You also have the right to a review of whether we have complied with the surprise billing and cost-sharing protections under the No Surprises Act, or if your denial is based on a determination that the health care services recommended or requested are experimental or investigational. You may submit a request for an independent external review to the Pennsylvania Insurance Department. This review would be at no cost to you.

**Standard Review**

Within four (4) months of receipt of this letter, you may file a request for an independent external review.

To request an independent external review online, please go to:

www.insurance.pa.gov/externalreview

You may also download and complete an independent external review request form from:

[Insurer URL]

Or

www.insurance.pa.gov/externalreview

Submit the complete request to the Bureau of Managed Care by:

Fax: 717-231-7960

or

Email: [RA-IN-ExternalReview@pa.gov](mailto:RA-IN-ExternalReview@pa.gov)

or

Mail: Pennsylvania Insurance Department

Attn: Bureau of Health Coverage Access, Administration, and Appeals

1311 Strawberry Square

Harrisburg, PA 17120

If your request is determined eligible for an independent external review, the Bureau of Health Coverage Access, Administration, and Appealswill assign an Independent Review Organization (IRO) to review your case. You will receive written notification of the IRO assigned to your case. You will also have the opportunity to submit information supporting your case to the IRO. The information you submit must be considered in the IRO’s review.

**Expedited Review**

You may request an expedited review if any of the following applies:

* You have a medical condition for which the time frame for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.
* Your denial is about an admission, the availability of care, or a continued stay or health care service for which you received emergency services, but you have not been discharged from the health care facility.
* Your denial is based on a determination that the recommended or requested health care services are experimental or investigational and your treating health care provider certifies in writing that the recommended or requested health care services would be significantly less effective if not promptly initiated.

Once you receive this letter, you may file a request for expedited independent external review if your denial is about one of the issues listed above. To request an expedited external review, your provider must complete the physician certification form included with the request form. Submit your form, the provider’s signed certification form, and any information you have to support your case, to the Bureau of Health Coverage Access, Administration, and Appeals by:

Fax: 717-231-7960

or

Email: [RA-IN-ExternalReview@pa.gov](mailto:RA-IN-ExternalReview@pa.gov)

**What happens next?**

If your request is determined eligible for independent expedited external review, the Bureau of Health Coverage Access, Administration, and Appealswill assign an Independent Review Organization to review your case.