NOTICE OF ADVERSE BENEFIT DETERMINATION
Macomb County Community Mental Health (MCCMH)

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."

Mailing Date: <*Mailing Date*>

Member ID: <*Member Plan ID*>

Name: <*Member's Name*>

Beneficiary ID: <*Member Medicaid ID*>

Adverse Benefit Determination / Action Decision Date: <*Decision Date*>

Adverse Benefit Determination / Action Effective Date: <*Effective Date*>

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.*]

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 MCCMH for an internal appeal within 60-calendar days of the mailing date of this notice. You, your representative or your provider {*provider*} can call or send in your request using the contact information below. With your request, you 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). If you are asking for a fast appeal you will need a provider's supporting statement in order for us to automatically give you 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. Call your provider if you need this information.
- A statement telling us if you would like to have your benefits continued while the appeal is pending.

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

There are 2 kinds of internal 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 you want to ask for an internal appeal, you can either call or send in a written request to:

Macomb County Community Mental Health
Local Appeal / Dispute Resolution Office
22550 Hall Road
Clinton Township, MI
MCCMH Ombudsman (586) 469-7795
TTY (800) 649-3777, or MI Relay Service at 711

Expedited or Fast Appeal – If you qualify for a fast appeal, we'll give you a decision within **72 hours** after we get your appeal. You can ask for a fast appeal if you or your provider believe your health or achievement of maximum function could be seriously harmed by waiting up to 30 calendar days for a decision. **We'll automatically give you a fast appeal if your provider tells us that your health or achievement of maximum function could be seriously harmed by waiting the standard timeframe.** If you ask for a fast appeal without this support from a provider, 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 (586) 469-7795 / TTY

(800) 649-3777 or MI Relay Service at 711. If you call on a weekend, holiday, or during non-business hours, you should leave a message that says that you would like a Fast Appeal.

Continuation of services during an Internal Appeal

If you are receiving a Michigan Medicaid service that is reduced, terminated or suspended before your current service authorization expires, and you file your appeal (with a request for continued benefits) within 10 calendar days of the mailing date on this Notice of Adverse Benefit Determination, <*insert 10 calendar day date*> (or before the Adverse Benefit Determination / Action Effective Date at the top of this letter), you will continue to receive your same level of services while your internal appeal is pending. You have the right to make this request, but you must state in your appeal request that you are asking for your service(s) to continue.

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. 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 at (586) 469-7958. Keep a copy for your records. If you want someone else to act for you and you have any questions or need help, call us at: (586) 469-7795. TTY users call (800) 649-3777 or MI Relay Service at 711.

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 at any time before or during the appeal. If you request an appeal, we will send these documents to you automatically. If you would like to request these documents before you request an appeal, or if you feel that MCCMH has any other information related to your appeal, you must submit your request for documents and information in writing. You can fax your written request to (586) 469-7958. If you have any questions or need help with your request for documents, call us at: (586) 469-7795. TTY users call (800) 649-3777 or MI Relay Service at 711.

What happens next?

- If you ask for an internal appeal and we uphold the denial of your request for coverage or payment of a service, we will send you a written Notice of Appeal Denial. After receiving a 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 internal appeal within the timeframes listed above, you may also seek a State Fair Hearing with the Michigan Grievance and Appeal Process System.

Get help & more information

- Macomb County Community Mental Health:
    - If you need help or would like more information about our decision or the internal grievance and appeal process, please call the MCCMH Ombudsman at (586) 469-7795, Monday–Friday, 8:30am–5:00pm.
    - TTY users call (800) 649-3777 or MI Relay Service at 711.
    - You can also visit our www.mccmh.net.
- 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).

Non-Discrimination and Accessibility

In providing behavioral healthcare services, Macomb County Community Mental Health complies with all applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Macomb County Community Mental Health does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

MCCMH 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, Braille)

MCCMH provides free language services to people whose primary language is not English or have limited English skills, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact Macomb County Community Mental Health Access Center at 1-855-996-2264.

If you believe that MCCMH 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: MCCMH Ombudsman at 22550 Hall Road, Clinton Township, MI 48036, 586-469-7795.

If you are a person who is deaf or hard of hearing, you may contact MCCMH at 1-800-649-3777 or MI Relay Service at 711 to request their assistance in connecting you to

MCCMH. You can file a grievance in person or by mail, fax or email. If you need help in filing a grievance, the MCCMH Ombudsman 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. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html. You may also file a grievance 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
Toll Free: 1-800-368-1019

You have the right to get this information in a different format, such as audio, Braille, or large font due to special needs or in your language at no additional cost.

English: ATTENTION: If you speak English, language assistance services, free of *charge, are available to you. Call 1-855-996-2264.*

Albanian: KUJDES: Në qoftë se ju flisni anglisht, shërbimet e ndihmës gjuhësore, pa pagesë, janë në dispozicion për ty. Telefononi 1-855-996-2264.

Arabic: تنبيه: إذا كنت تتحدث العربية فإن خدمة الترجمة متوفرة لك مجاناً فقط إتصل على الرقم 1-855-996-2264

Bengali: দৃষ্টি আকর্ষণ: আপনি ইংরেজি, ভাষা সহায়তা সেবা, নিখরচা কথা বলতে পারেন, আপনার জন্য উপলব্ধ. কল 1-855-996-2264.

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-855-996-2264.

German: Achtung: Wenn Sie Englisch sprechen, sind Sprache Assistance-Leistungen, unentgeltlich zur Verfügung. Rufen Sie 1-855-996-2264.

Italian: Attenzione: Se si parla inglese, servizi di assistenza di lingua, gratuitamente, sono a vostra disposizione. Chiamare 1-855-996-2264.

Japanese: 注意: 英語を話す言語アシスタンス サービス、無料で、あなたに利用できま。を呼び出す) 1-855-996-2264.

Korean: 주의: 당신이 영어, 언어 지원 서비스를 무료로 사용할 수 있습니다 당신에 게. 전화1-855-996-2264.

Polish: UWAGI: Jeśli mówisz po angielsku, język pomocy usług, za darmo, są dostępne dla Ciebie. Wywołanie 1-855-996-2264.

Russian: ВНИМАНИЕ: Если вы говорите по-английски, языковой помощи, бесплатно предоставляются услуги для вас. Звоните 1-855-996-2264.

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite (TTY- Telefon za osobe sa oštećenim govorom ili sluhom:) 1-855-996-2264.

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-996-2264.

Syriac: ܙܘܗܪܐ ܬܗܡܕܐ ܥܠ ܗܠܝܢ ܡܕܟܬܐ ܒܐܗܡܝܡܐ ܡܥܝܠܦܐ ܐܢܝ ܠܦܦܐ ܩܠܢܐ، ܘܐܬܘܪܝܐ ܒܪܐܬܠ،
ܒܦܘܪܬܐ ܐܘ 1-855-996-2264.
ܐܪܟܐ1-855-996-2264. ܒܟܠܬ ܗܡܘܬܬܐ ܐܘ ܟܠܥܢܝ ܟܠܟܢ ܠܐܥܟܐ ܠܕܬܪܐ . ܐܡܬ ܬܠ ܠܝ

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-855-996-2264.

Vietnamese: Chú ý: Nếu bạn nói tiếng Anh, Dịch vụ hỗ trợ ngôn ngữ, miễn phí, có sẵn cho bạn. Gọi 1-855-996-2264.