

Attachment D

Insert Logo Here

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what you asked for, what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si usted no entienda esta carta o usted tiene alguna pregunta por favor de llamar al XXXXXX-XXXX o (800) XXX-XXXX. Esta carta esta disponible en otras idiomas y formato si es que lo necesita.)

NOTICE OF EXTENSION

TO:

Date:

FROM: (clinic full name)

(Your doctor OR name of provider- as appropriate) have asked that (Health Plan Name) pay for (describe services requested and the reason for the services in easily understood language).

(You or the name of requesting provider – if the member or requesting provider has requested the extension OR Health Plan name) feels that it is in your best interest to try to take fourteen (14) more days to make a decision. We need this time so we can get more information from (insert name of requesting provider). We need (insert what additional information is needed, e.g. notes from your doctor that tell us if you have tried Drug X before , or notes from your doctor that tell us if you have had a chest x-ray. Be as specific as possible in what information is needed in order to assist the member in getting the service or provides the member with an idea of what information is missing that the member may be able to supply).

We will make this decision by (insert date the extension expires; this cannot exceed 14 days from the date of the extension letter and cannot exceed 28 days from the date of request. For example, if you issue/mail the Notice of Extension on Day 6 of the request timeframe, and you give fourteen (14) additional days, the decision must be made by the twentieth (20th) day of the request. The timeframe is counted from the date on the letter which represents the mail date)

If we do not get the information from (insert name of requesting provider) then we will have to deny this request.

If you do not agree with us taking this extra time to make a decision you can file a grievance (complaint). You can do this by contacting (insert the Contractor's grievance

Effective: 10/01/2009

**For translation or alternative format requests, call [1-800-640-2123 or 774-7128]
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phone number and insert the address for grievances).

As your health plan, we can decide to take this extra time if we feel it will be of help to you. We felt this extra time would help us to get the extra (notes or tests) that would help us make this decision.

Sincerely,
(Insert name of Health Plan)

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