PM FORM 5.1.1

NOTICE OF ACTION

TO: [ENROLLEE'S NAME/ADDRESS] [REPRESENTATIVE NAME/ADDRESS]

FROM: (Name of agency)
(Address)
CONTACT PERSON/NUMBER

OUR DECISION:

We have decided to take the following action that affects your behavioral health services:

- ❑ Deny or limit your request for (***insert requested service here).***
- ❑ Reduce ***(service)*** from ***(insert current frequency)*** to ***(proposed frequency)***
- ❑ Suspend ***(insert service)***____
- ❑ Terminate ***(insert service)***____________________________________
- ❑ Deny your request to obtain ***(insert requested service)*** outside our service provider network.

The effective date of this decision is: ___________________________________

The reason for our decision is: ____

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YOUR RIGHT TO APPEAL:

How to Appeal Within 60 days of this decision, you may appeal orally by calling [local number] or [toll free number], or in writing by completing PM Form 5.3.1, ADHS/DBHS Appeal or SMI Grievance Form, and sending it to[address]. Your behavioral health provider can appeal for you if you give your written permission. Standard appeals are resolved within 30 days. When you file an appeal, you may ask for an "expedited appeal" if the standard 30-day timeframe could result in serious harm to your life, or health or in your ability to attain, regain or maintain maximum function. Expedited appeals will be resolved within 3 working days. If your health care provider tells us this, the appeal will be decided in 3 working days.

Request for Continued Benefits

You may request that the service listed in this letter continue during the appeal process. If you want the service to continue, you must say so when you appeal. Your services will only be continued if you appeal by the later of: 10 days from the date of this Notice; or, the date that the services will be terminated or reduced. This only applies if we are cutting off a service that we have already approved AND if the service was ordered by your doctor or other behavioral health care provider. If you do not win your appeal, you may be responsible for paying for the service provided during the appeal.

For persons with a serious mental illness (SMI), the service being reduced, suspended or terminated will be continued when you file an appeal, unless doing so would be harmful to your health and safety, or to another individual. Services will be continued throughout the appeal process. You will not be required to pay for the cost of services continued during the appeal.

HOW TO GET HELP WITH YOUR APPEAL:

To get help with this appeal you may contact the State Protection and Advocacy System, the Arizona Center for Disability Law 1-800-922-1447 in Tucson and 1-800-927-2260 in Phoenix. Persons with a serious mental illness (SMI) may contact an Advocate at the Office of Human Rights at 1-602-364-4585 or 1-800-421-2124. For more information about the reasons for our decision, you may contact the person whose name and address appears at the top of this notice. You may also refer to your member handbook for more information about the appeals process.

____ _________________________________

Name and Signature of Individual Completing this Form Date of Hand Delivery or Mailing

Last Revised: 02/02/2006

For translation or alternative format requests, call [insert 1-800 and local number]
Para recibir esta forma en español, llame a: [insert 1-800 and local number]