

## PM FORM 5.1.1

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 letter is available in other languages and formats if you need it.

Si usted tiene problemas leyendo éste aviso debido a que las letras son muy pequeñas o las palabras son muy difíciles de leer, por favor llame a nuestra oficina al XXX-XXX-XXXX y alguna persona le ayudará. Si éste aviso no le proporciona la información que usted busca o la decisión que tomamos y el por qué, por favor llámenos al número XXX-XXX-XXXX. Esta comunicación está disponible en otros idiomas y formatos si usted lo necesita.

### [Forma PM 5.1.1 versión en español](#)

## NOTICE OF ACTION

**TO:**

**Date:**

**FROM:**

You or your health care provider have asked that (*RBHA or RBHA Contractor*) pay for (*describe services requested and the reason for the services in easily understood language*).

### **OUR DECISION**

*(Insert action being taken here and date effective if terminating or reducing a current service).*

### **THE REASONS FOR OUR DECISION**

#### Facts About Your Condition or Situation that Support Our Decision

*(Insert the reason for the action, which must be complete and in commonly understood language. The explanation must be both member and fact specific, describing the member's condition and the reasons supporting the RBHA or Contractor decision. If the reason for the denial is a lack of information, the missing information must be identified so the member has an opportunity to provide it.)*

#### Legal Basis for Our Decision

We based our decision on (*insert correct legal citation here*).

Effective: 09/01/2008

**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]**

Copies of Legal Citations can be found at the local library or at <http://azahcccs.gov/regulations/lawsregulations/>.

## **YOUR RIGHTS IF YOU DISAGREE WITH THIS DECISION**

If you are not happy with this decision, you can ask us to look at the decision again. This is called an appeal. You can appeal by telling us over the phone or in writing. You must call us at *(Insert grievance phone number)* or write us by completing **PM Form 5.3.1, ADHS/DBHS Appeal or SMI Grievance form**, by *(insert date, no later than 60 calendar days after the date of this Notice)*.

If you are writing your appeal, please send it to *(insert Contractor mailing address here)*.

You can also see your medical records and get other information about your appeal. Before we make our decision, you can give us any information that you think will be helpful. You can ask us to set up a meeting so that you can give us the information in person, or you can give it to us in writing.

After we review your appeal, we will send you our decision in writing within 30 days of the date we received your appeal request.

## **IF YOU NEED A FASTER DECISION ON YOUR APPEAL**

If you or your health care provider believes that your health or ability to function will be harmed unless a decision is made in the next three days, you or your health care provider can ask us for a fast review by calling us and asking for an expedited appeal. If we agree, we will decide your appeal in 3 working days. If we do not agree a fast review is needed, we will write you within 2 days, and we will also try to call you. Then, we will decide your appeal within 30 days.

## **GETTING HELP IF YOU WANT TO APPEAL THIS DECISION**

You can have someone help you appeal. Your doctor or other health care provider can appeal for you if you write to us giving them permission.

If you would like legal help with this decision, you can ask for it by contacting the legal aid program in your county listed on the attached sheet. You may also contact the State Protection and Advocacy System, the Arizona Center for Disability Law, at 1-800-922-1447 in Tucson, or 1-800-927-2260 in Phoenix. Persons determined to have a serious mental illness (SMI) may also ask for help by contacting an Advocate at the Office of Human Rights at 1-800-421-2124 or 1-602-364-4585.

Effective: 09/01/2008

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**CONTINUING SERVICES WHILE WE MAKE A DECISION ON YOUR APPEAL (Insert: “This paragraph does not apply to you” if the member has not been receiving the requested service).**

If the services you write about in your appeal are already being given to you, but are going to be cut back or stopped, you can ask that the services continue while we make a decision. If you want those services to continue, you must say so when you appeal. Your services will only be continued if you appeal by *(insert date, the later of 10 calendar days from the date of the Notice OR the intended date of the action)*. If you do not win your appeal, you may be responsible for paying for these services provided during the appeal.

If you are a person determined to have a serious mental illness (SMI), the services being appealed will be continued when you file an appeal, unless continuing the services would be harmful to your health and safety, or to another person. The services being appealed will be continued throughout the appeal process. You will not have to pay for the cost of these services provided during the appeal.

**TAKING MORE THAN 30 DAYS TO DECIDE YOUR APPEAL**

For all appeals, up to 14 more days may be taken to make a decision on your case. This is called an extension. If we want an extension, we will write you and tell you why it is needed and how it is helpful to you. If you want an extension, you can ask for it by writing or calling us. If an extension is given, a decision in your appeal will be made in 44 days, rather than 30 days

If you have any questions about filing an appeal or if you need help, you can call us at *(insert Contractor phone number here)*.

Sincerely,

*(Insert name of Decision Maker)*

Effective: 09/01/2008

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