«DATE»

Recipient Name

{{address}}

{{city}}, ST 00000

**Notice of Adverse Benefit Determination**

Date of Notice: Today’s Date

Name of Plan: Plan Name

{{address}}:

Telephone/Fax: Plan Phone/Fax Number

Website: Plan Website

**This document contains important information that you should retain for your records.**

[Healthcare Management is a Department of Luminare Health Benefits, Inc. that conducts utilization review for your employer’s ERISA self-funded benefit plan. *Remove this bracketed section if using the client’s letterhead.]*

This document serves as notice of an adverse benefit determination. Benefits under your choose self-funded or insured benefit plan are denied in whole or in part for the requested treatment or service described below. If you think this determination was made in error, you have the right to appeal.

**Explanation of Basis for Determination:**

If the authorization is denied (in whole or in part) and there is more explanation for the basis of the denial, such as the criteria, plan or policy benefit, include that information here

*[Using the specific plan language for bringing legal action, include the timeframe to bring such action. In the National Plan document this is found under General Provisions. For West standard plan documents, this wording is found in General Information. For Central standard plan documents, this wording is found in the Appeals section. Then remove this section in italics. Example sentence using language from National Plan document-* All claim review procedures provided for in your Plan Document must be exhausted before any legal or equitable action is brought.Notwithstanding any other state or federal law, any and all legal actions to recover benefits, whether against the Plan, plan administrator/claims processor, any other fiduciary, or their employees, must be filed within two (2) years from the date the expense was incurred or one (1) year from the date the completed claim was filed, whichever occurred first. *]*

**Offer of Language Assistance**

SPANISH (Español): Para obtener asistencia en Español, llame al insert phone # for Spanish line.

TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa insert phone # for Tagalog line.  
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码insert phone # for Chinese line。

NAVAJO (Dine): Dinek'ehgo shika at’ohwol ninisingo, kwiijigo holne' insert phone # for Navajo line.

**Important Information about Your Appeal Rights**

**What if I need help understanding this adverse determination notice?** Please contact the Healthcare Management Department at 1-800-480-6658, ext. 15605, from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday or fax to 1-888-708-0854.

**What if I don’t agree with this decision?** You have a right to appeal any adverse determination notice.

**How do I file an appeal?** Complete the bottom of this page, make a copy, and send the information to the Healthcare Management Department at the mailing address listed below within 180 days from receipt of the notification of adverse benefit determination. See also the “Other resources to help you” section of this form for assistance filing a request for an appeal.

You may **telephone** us with your **urgent** or **non-urgent** request, at 800-480-6658, ext. 15605 from 8:00am to 5:00pm Eastern Standard Time, Monday through Friday.

You may **mail** your **non-urgent** request to:

Healthcare Management Department,

Attn: Appeals Physician Review

PO Box 83301

Lancaster Pennsylvania, 17608-3301.

**Please be advised**that postal service deliveries are monitored only during regular business hours, 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday.

You may **FAX**your non-urgent request to 717-295-1208, from 8:00 am to 5:00 pm Eastern Standard Time, Monday through Friday. **Please be advised**that FAX transmissions are monitored only during these regular business hours.

**What if my situation is urgent?** If your situation meets the definition of urgent under the law, your review will generally be conducted within 72 hours. Generally, an urgent situation is one in which your health may be in serious jeopardy, or, in the opinion of your physician, you may experience severe pain that cannot be adequately controlled without immediate treatment. If you believe your situation is urgent, you may request an expedited appeal by following the instructions above for filing an internal appeal and also by filing a request for simultaneous external review to the following address:

HealthCare Management

Attn: Appeals Physician Review, URGENT

1280 N. Plum Street,

Lancaster, PA 17601-3301

**Who may file an appeal?** You or someone you name and agree in writing to act for you (your authorized representative) may file an appeal.

**Can I provide additional information about my claim?** Yes, you may supply additional information in support of your case to the following address:

HealthCare Management

Appeals Physician Review

1280 N. Plum Street,

Lancaster, PA 17601

**Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge). If you think a coding error may have caused this claim to be denied, you have the right to have billing and diagnosis codes sent to you, as well. You can request copies of this information by contacting HealthCare Management at 1-800-480-6658 ext:15605.

**What happens next?** If you appeal, we will review the decision and provide you with a written determination. If we uphold the original decision of the requested service, or you do not receive a timely decision, you may be able to request an external review of medical necessity by an independent third party, who will review the determination and issue a final decision.

External review applies to an adverse benefit determination including, but not limited to, those plan requirements involving medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, or experimental or investigational treatments or services.

**Other resources to help you:** For questions about your rights, this notice, or for assistance, you can

contact: the Employee Benefits Security Administration at 1-866-444-EBSA (3272)] [and/or] [if coverage is insured, delete this text, and insert {{stateCode}} Department of Insurance contact information].

**Appeal Filing Form**

**NAME OF PERSON FILING APPEAL:**

**Circle relation to patient:** Covered person Patient Authorized Representative

**Contact information of person filing appeal (if different from patient)**

{{address}}: Daytime phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:**

**If person filing appeal is other than patient, patient must indicate authorization by signing here:**

**Patient Signature:**

**Are you requesting an urgent appeal?** ⁪Yes ⁪ No

**Briefly describe why you disagree with this decision** (you may attach additional information, such as a physician’s letter, bills, medical records, or other documents to support your claim)**:**

Send this form and your denial notice to: Appeal Mailing Address

**Be certain to keep copies of this form, your denial notice, and all documents and correspondence related to this claim.**