

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. If you are deaf or have difficulty hearing, you can call **7-1-1**.

~~Si tiene problemas para leer este aviso porque las letras son muy pequeñas o las palabras son difíciles de leer, por favor llame a nuestra oficina al XXX XXX XXXX y alguien le ayudará. Si esta notificación no le dice lo que usted pidió, lo que decidimos y por qué, por favor llámenos al XXX XXX XXXX. Este aviso está disponible en otros idiomas y formatos si lo necesita. Si usted es sordo o tiene dificultades de audición, comuníquese al 7-1-1.¹~~

NOTICE OF EXTENSION

To : _____ DATE : _____
FROM: _____

(Your doctor OR name of provider- as appropriate) has 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 take up to 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 17 days from the date of an expedited request or 28 days from the date of a standard request. For example, if you issue/mail the Notice of Extension on day six of the request timeframe, and you give 14 additional days, the decision must be made by the 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

¹ POST APC CHANGE: removed, information is duplicative of the non-discrimination notice that will be included in the notice

information from *(insert name of requesting provider)* then we will have to deny this request.

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

If you need help with making a complaint, you may contact the State Protection and Advocacy System, the Arizona Center for Disability Law at 1-800-927-2260. Persons with a Serious Mental Illness (SMI) may contact an advocate at the Office of Human Rights at 602-364-4585 or 1-800-421-2124. You may also refer to your member handbook for more information about the service authorization process.

As your health plan, we can decide to take extra time if we feel it will be of help to you. We felt extra time would help us get the information needed to make a decision.

Sincerely,

(Insert name of Health Plan)

OPEN UNTIL 11/15/18