

<<IPA LOGO>>

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

Member Name: <Member Name>
Member ID #: <Member ID>
Health Plan Name: IEHP DualChoice (HMO D-SNP)
Health Plan Phone #: 1-877-273-IEHP (4347) or for TTY users 1-800-718-4347
Health Plan Hours of Operation: 8am-8pm (PST), 7 days a week, including holidays
Physician Name: <PCP>
Requested Service: <Service>
Date and Time of Expedited Request: <MM/DD/YYYY; HH:MM>
Attending Physician's Name: <PCP>

Dear <Member's Name>:

We hope this letter finds you well. We are writing about your request for an expedited determination (within 72-hours of when you asked) to approve the services noted above.

We are sorry to say your request does not meet the Centers for Medicare & Medicaid Services (CMS) definition of an "expedited determination." To get an expedited determination, the following two rules must be met:

- (1) You must have not yet received the care or item in which you are asking for coverage. (You cannot get an expedited determination if your request is about payment for care or an item you have already received.)
- (2) The standard 14 calendar day deadline will have to cause serious harm to your health or hurt your ability to function in order to get an expedited determination.

Since your request has not met either of these two conditions, it has been forwarded to the standard review process.

Please know we will make every effort to process your request as soon as possible, and no later than fourteen (14) calendar days after the date in which we got your request. Once the review is finished, we will be sure to let you know.

You have the right to resubmit a request for an expedited determination. If your Doctor supports your request for an expedited determination, and the Doctor indicates that waiting for fourteen (14) days could cause serious harm to your health, then we will give you one.

You may also file an expedited oral or written grievance with IEHP DualChoice about our decision not to expedite your review. The grievance process allows a Member to file a complaint

with IEHP DualChoice about issues other than denied claims or services. IEHP DualChoice must respond to an expedited grievance within twenty-four (24) hours.

To file an expedited grievance, you or your authorized representative should call, mail or fax your written grievance to:

IEHP DualChoice
P.O. Box 1800
Rancho Cucamonga, CA 91729-1800
Toll Free: 1-877-273-IEHP (4347) or for TTY Users: 1-800-718-4347
Fax: 1-909-890-5748

Also, please note that although you do not have to submit more information to <<IPA>>, it is important you contact them if your medical condition changes or if you have more information about your case.

Please direct any further questions or information to <<IPA>> Member Services at <<IPA Phone Number>>, <<IPA Hours of Operation>>. TTY users should call <<TTY Number>>.

Thank you for being a valued Member of <<IPA>> and for trusting us with your health care needs.

To your health,

<<IPA>>

IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.