WEST MICHIGAN COMMUNITY MENTAL HEALTH
NOTICE OF ADVERSE BENEFIT DETERMINATION AND APPEAL RIGHTS

Date: _____ Name: _____ Birthdate: _____ Case No.: _____

Guardian/Parent (as applicable): _____

This is to notify you that we have made the following decision(s) about the service(s) you have asked for or about the service(s) you receive. The legal basis for this decision is 42 CFR 440.230 (d); the Michigan Mental Health Code; Act 258 of the Public Acts of 1974 as amended; and/or the Medicaid Provider Manual. You have the right to receive copies, free of charge, for all records and information relevant to the enrollee's claim for benefits. The Adverse Benefit Determination being taken is:

☐	**ADEQUATE NOTICE (at the time of the Adverse Benefit Determination)**	**Service(s) Affected**
☐	Denial or limited authorization of a requested service (including type or level of service	
☐	Denial, in whole or in part, of payment for a service	
☐	Failure to provide services within 14 calendar days of the agreed upon start date	
☐	Failure to make an authorization decision within the required time frames	
☐	Failure to act on a local appeal within the required time frames	
☐	Failure to provide disposition of a grievance within 60 calendar days	
☐	Administrative discontinuation of services	
☐	Your person-centered plan dated has been completed	

☐	**ADVANCE NOTICE** **(Medicaid: At least 12 calendar days before Adverse Benefit Determination)** **(Non-Medicaid: At least 30 calendar days before Adverse Benefit Determination)**	**Service(s) Affected**	**Effective Date**
☐	Reduction of previously authorized service		
☐	Suspension of previously authorized service		
☐	Termination of previously authorized service		

The reason for this Adverse Benefit Determination is:

☐ The service(s), or the amount, scope or duration of service(s) identified in this notice are not clinically appropriate, or necessary, to meet your needs, or consistent with your diagnosis, symptoms or impairments, or the most cost effective option in the least restrictive environment, or consistent with current/clinical standards of care.

☐ Your Individual Plan of Service goals and objectives have been met.
☐ We cannot continue to authorize services for you if you are not participating in treatment.
☐ You do not meet clinical eligibility criteria for services as:
  ☐ A person with a serious mental illness
  ☐ A person with a developmental disability
  ☐ A child with a serious emotional disorder
  ☐ A person with a substance use disorder
☐ Your Medicaid Health Plan is responsible for providing services to you
Please contact your Health Plan: _____ Phone Number: _____
☐ You no longer have Medicaid coverage. If you believe you still need services, please contact _____ to request general fund services. Please note that individuals who do not have Medicaid may be placed on a waiting list.
☐ You have voluntarily requested termination of your services.
☐ Other: _____

Recommended Services/Supports: _____

This notice was provided to _____ on _____ via ☐ Mail ☐ In person
Name Date

Staff Signature and Credentials or Job Title: _____ Date: _____

IF YOU ARE CURRENTLY A MEDICAID BENEFICIARY

AND YOU DO NOT AGREE WITH THIS ADVERSE BENEFIT DETERMINATION, YOU HAVE THE FOLLOWING RIGHTS:

Local Appeal Process	Fair Hearing
You may request a local appeal within 45 calendar days of the date on this notice. Your appeal will be resolved within 30 calendar days of receipt. If you believe waiting the standard timeframe for the appeal to be resolved could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, you can ask for an expedited or faster local appeal. During the appeal process you have the right to provide us additional information and have someone speak for you regarding the appeal. You or your authorized representative also has the right to review your appeal file before and during the appeal process. Local appeal requests can be made orally or in writing. An oral request must be confirmed in writing unless an expedited local appeal has been requested. To request a local appeal, contact: **CUSTOMER SERVICES** **Lakeshore Regional Entity** **5000 Hakes Drive, Suite 500** **Norton Shores, MI 49441** **Toll Free: 1-800-897-3301** **Fax: 1-231-769-2075**	You may request a Medicaid Fair Hearing within 120 calendar days of the date on this notice. You do not have to go through the local appeal process in order to request a hearing. You may request both processes at the same time, or you may choose one and not the other. If you believe waiting the standard timeframe for the hearing to be resolved could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, you can ask for an expedited or faster hearing. The Michigan Administrative Hearing System will decide whether to grant your request for an expedited hearing so you must contact them directly at (877) 833-0870. During the hearing processes you can represent yourself or have another person represent you. This person can be anyone you choose. You must give this person written permission to represent you. If this person is your guardian or conservator you must provide a letter or a copy of the court order. This person may also request a hearing for you. Hearing requests must be made in writing and signed by you or your authorized representative. To request a Hearing, you may complete the "Request for Hearing" form, or submit a request in writing on any paper, and mail or fax to: **Michigan Administrative Hearing System** **For the Department of Health and Human Services** **PO Box 30763** **Lansing, MI 48909** **Fax (517) 373-4147**

If you have Medicaid and are receiving an Advance Notice of Adverse Benefit Determination involving the reduction of a currently authorized service, you may request to have your services continue while your appeal is pending if you file an appeal within 12 calendar days of the date of notice and the original authorization period has not expired. Please note that if services are continued we have the right to ask you to repay the cost of these services if the hearing or appeal upholds the original decision, or if you withdraw your appeal or hearing request, or if you or your authorized representative does not attend the hearing.

IF YOU ARE NOT CURRENTLY A MEDICAID BENEFICIARY

AND YOU DO NOT AGREE WITH THIS ADVERSE BENEFIT DETERMINATION, YOU HAVE THE FOLLOWING RIGHTS:

Local Appeal Process	Alternative Dispute Resolution Process
You may request a local appeal orally or in writing within 5 days of the date on this notice. If you believe waiting the standard timeframe for the appeal to be resolved could seriously jeopardize your life or health or ability to attain, maintain or regain maximum function, you can ask for an expedited or faster local appeal. To request a local appeal, contact: **CUSTOMER SERVICES** West Michigan Community Mental Health Services 920 Diana St. Ludington MI 49431 231-845-6294 TTDY: 800-790-8326	If you are not satisfied with the result of the Local Appeal, you may request the Alternative Dispute Resolution process through the Michigan Department of Health and Human Services within 10 calendar days of the notice on the local appeal decision. To request a review, submit your request in writing to: **Michigan Department of Health and Human Services** **Program Development, Consultation and Contracts Division** **Behavioral Health & Developmental Disabilities Administration** **ATTN: Request for MDHHS Level Dispute Resolution** **Lewis Cass Building – 320 S Walnut St** **Lansing, MI 48913**