

**OHIO DEPARTMENT OF INSURANCE  
MODEL NOTICE OF ADVERSE BENEFIT DETERMINATION**

<b>DATE OF NOTICE:</b>	<input type="checkbox"/> Initial Notice <input type="checkbox"/> First Level Appeal Notice
<b>HEALTH PLAN ISSUER:</b>	<b>TELEPHONE:</b> <b>FAX:</b>
<b>MAILING ADDRESS:</b>	<b>EMAIL ADDRESS:</b> <b>WEBSITE ADDRESS:</b>

**THIS DOCUMENT CONTAINS IMPORTANT INFORMATION THAT YOU SHOULD RETAIN FOR YOUR RECORDS**

This document serves as notice of an Adverse Benefit Determination. An Adverse Benefit Determination is a decision we make not to provide benefits because we believe they are not medically necessary, you are not eligible for this benefit or the benefit is not covered under your plan. It can also be a decision to deny health benefit plan coverage or to rescind coverage. We will not provide benefits for the reason indicated below. If you think this determination was made in error, you have the right to appeal (see the Important Information About Your Appeal Rights section of this notice).

☐ We have declined to provide benefits, in whole or in part, for the requested treatment or service described below.

☐ We have declined to issue health benefit plan coverage to you through an individual policy or non-employer group certificate.

☐ We have decided to rescind your health benefit plan coverage. To rescind means when we cancel or discontinue coverage back to the original effective date as if the coverage never existed.

**Case Details**

**Covered Person/Applicant Name:**

**Health Benefit Plan/Application ID Number:**

**Mailing Address:**

**Reason for Denial:**

**Standard Used in Making the Decision:**

**Explanation of Basis for Decision:**

**Claim Denial Information (if applicable)**

**Claim Number:**

**Date of Service:**

**Health Care Provider:**

**Description of Service:**

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Billed Amount	Allowed Amount	Other Insurance	Deductible	Copayment	Coinsurance	Other Amts Not Covered	Amount Paid

**YTD Credit toward Deductible:**

**YTD Credit toward Out-of-Pocket Maximum:**

**Denial Code(s):**

**Important Information about Your Appeal Rights**

**What if I need help understanding this denial?** If you need assistance understanding this notice or our decision to deny you a service or coverage please contact us at:

Phone Number and Fax Number

Email Address

Mailing Address

**What if I don't agree with this decision?** You have a right to appeal any decision to decline to provide or pay for any item or service (in whole or in part), not to issue health benefit plan coverage to you, or to rescind your coverage.

**How do I file an appeal?** Complete the Appeal Request Form, keep a copy for yourself and send the form to us at any of the following addresses:

Fax Number -

Email Address

Mailing Address

Please see the "Other resources to help you" section of this form for assistance filing a request for an appeal.

**What if my situation is urgent?** If your situation meets the definition of urgent as shown below, your review will generally be conducted within 72 hours. An urgent situation is one in which your health or life may be in serious jeopardy, you may not be able to regain maximum function if treatment is delayed or, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. If you believe your situation is urgent, you may request an expedited appeal by checking the appropriate box on the Appeal Request Form. If your treating physician believes you will require a Concurrent Expedited Internal Appeal and Expedited External Review due to your urgent medical condition or a proposed experimental or investigational treatment that must begin promptly, please check the appropriate box on the Appeal Request Form. Your doctor must complete the Treating Physician Certification Form for Internal Appeal and/or External Review to verify your situation.

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**Who may file an appeal?** You, someone you name or someone who is authorized by law to act for you (your authorized representative) may file an appeal. Please complete the Appointment of Authorized Representative section of the Appeal Request Form.

**Can I provide additional information about my claim?** Yes, you may supply additional information. Please forward your information along with a copy of this Notice of Adverse Benefit Determination to any of the following addresses:

Fax Number -

Email Address -

Mailing Address

**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 us at:

Phone Number:

Fax Number

Email Address

Mailing Address

**What happens next?** If you request an appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage or service requested or you do not receive a decision within 30 days, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision. Please refer to the attached External Review Procedures Summary for more information.

**Other resources to help you:**

For questions about your rights, this notice, or for further assistance you may contact:

Ohio Department of Insurance  
ATTN: Consumer Affairs  
50 West Town Street, Suite 300, Columbus, OH 43215  
800-686-1526 / 614-644-2673  
614-644-3744 (fax)  
614-644-3745 (TDD)

Contact ODI Consumer Affairs:

<https://gateway.insurance.ohio.gov/UI/ODI.CS.Public.UI/Complaint.mvc/DisplayConsumerComplaintForm>

File a Consumer Complaint:

<http://insurance.ohio.gov/Consumer/OCS/Pages/ConsCompl.aspx>