**AmeriHealth Insurance Company**
1901 Market Street
Philadelphia, PA 19103-1480

# NOTICE OF NONCOVERAGE OF CUSTODIAL CARE

**Member Name:**

**Member ID#:**

**Date of Admission/Readmission to Facility:**

**NOTE:** You need to make a choice about receiving custodial care services.

You are being admitted/transferred for custodial care services. These services have been recommended by your doctor. Neither AmeriHealth 65 nor Medicare pays for custodial care. AmeriHealth 65 only pays for covered items and services when Medicare rules are met. The fact that AmeriHealth 65 may not pay for a particular item or service does not mean that you should not receive it.

The purpose of this form is to help you make an informed decision about whether or not you want to receive custodial care services knowing that you will have to pay for these services yourself. If you do receive custodial care services, you will be fully responsible for payment. That is, you will pay personally, out-of-pocket for the cost of custodial services. Any other services which Medicare covers as Part B services, will be paid by AmeriHealth 65. If you do not agree with this decision, you have the right to appeal.

I understand that my signature on this notice means that I read and understand the contents of this document.

_____ **Date**

_____ **Signature of patient or person acting on patient's behalf**

_____ **Relationship of the person acting on behalf of The Patient if not self**

## NOTICE OF NONCOVERAGE OF CUSTODIAL CARE

### What If I Don't Agree With This Decision?

**You have the right to appeal.** To exercise it, file your appeal in writing within 60 calendar days after the date of this notice. We can give you more time if you have a good reason for missing the deadline.

### Who May File An Appeal?

You or someone you name to act for you (your **authorized representative)** may file an appeal. You can name a relative, friend, advocate, attorney, doctor, or someone else to act for you. Others also already may be authorized under State law to act for you.

You can call us at: 1-800-645-3965 to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY/TDD 1-888-857-4816.

If you want someone to act for you, you and your authorized representative must sign, date, and send us a statement naming that person to act for you.

## IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

**For more information about your appeal rights, call us or see your Evidence of Coverage.**

**There Are Two Kinds of Appeals You Can File**

**Standard (30 days)-** You can ask for a standard appeal. We must give you a decision no later than 30 days after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.)
**Fast (72 hour review)-** You can ask for a fast appeal if you or your doctor believe that your health could be seriously harmed by waiting too long for a decision.
We must decide on a fast appeal no later than 72 hours after we get your appeal. (We may extend this time by up to 14 days if you request an extension, or if we need additional information and the extension benefits you.

- **If any doctor** asks for a fast appeal for you, or supports you in asking for one, and the doctor indicates that waiting for 30 days could seriously harm your health, **we will automatically give you a fast appeal.**
- If you ask for a fast appeal without support from a doctor, we will decide if your health requires a fast appeal. If we do not give you a fast appeal, we will decide your appeal within 30 days.

**What Do I Include With My Appeal?**
You should include: your name, address, Member ID number, reasons for appealing, and any evidence you wish to attach. You may send in supporting medical records, doctors' letters, or other information that explains why we should provide the service. Call your doctor if you need this information to help you with your appeal. You may send in this information or present this information in person if you wish.

**How Do I File An Appeal?**

**For a Standard Appeal:** You or your authorized representative should mail or deliver your written appeal to the address(es) below:

AmeriHealth 65 Member Appeals Unit
P.O. Box 41820
Philadelphia, PA 19101-1820

**For a Fast Appeal:** You or your authorized representative should contact us by telephone or fax:

**Toll free:** 1-800-645-3965
**TDD/TDY:** 1-888-857-4816
**Fax:** 1-215-988-2001

**What Happens Next?** If you appeal, we will review our decision. After we review our decision, if any of the services you requested are still denied, Medicare will provide you with a new and impartial review of your case by a reviewer outside of your Medicare+Choice Organization. If you disagree with that decision, you will have further appeal rights. You will be notified of those appeal rights if this happens.

**Contact Information:**
If you need information or help, call us at:

**Toll Free:** 1-800-645-3965
**TTY/TTD:** 1-888-857-4816

**Other Resources To Help You:**
Medicare Rights Center:
Toll Free: 1-888-HMO-9050

Elder Care Locator
Toll Free: 1-800-677-1116
1-800-MEDICARE (1-800-633-4227)
TTY/TTD: 1-877-486-2048