Pennsylvania Specific Information

This document contains information specific to the State of Pennsylvania. Please refer to the Provider Reference Guide for general information regarding plan administration.

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1.1 Notice of Updates

Notice of updates published March 21, 2025.

- Updated Eyewear After Cataract Surgery.

1.2 Covered Benefits - UnitedHealthcare Community Plan for Kids (CHIP)

Benefit Plan(s): UDPAMCHIP2

Benefit	Benefit Limitations/Criteria
Exam	▪ 1 service date every year. ▪ Includes dilation, if professionally indicated.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Frame	▪ 1 unit every year. ▪ Frames may be selected from the March frame kit **OR** a $130 retail allowance may be used toward any frame in the provider's selection. To identify frames within the provider's selection, please bill using modifier code 75 in conjunction with procedure code V2020. ▪ If the member selects the $130 retail allowance, expenses in excess of $130 are payable by member.
Frame Replacement	▪ 1 unit every year if lost, stolen or damaged when medically necessary.

Lens (Single, Bifocal, Trifocal, Lenticular)	▪ 2 units every year.
	▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. Provider is responsible for the cost of traceable shipping of a non-March frame to the March lab for lens fabrication.**
	▪ Plastic or glass regular single vision, bifocal, trifocal or lenticular lenses.
	▪ The following lens options are fully covered.
	  ▪ Oversize lenses.
	  ▪ Fashion and gradient tinting.
	  ▪ Oversized glass-grey #3 prescription sunglass lenses.
	  ▪ Scratch resistant coating.
	  ▪ Ultraviolet Protective Coating
	▪ Specified copays apply to the following lens options. Prices stated are per lens.
	  ▪ Polycarbonate Lenses (if not child, monocular or prescription >+/-6.00 diopters) - $2.00
	  ▪ Blended Segment Lenses - $10.00
	  ▪ Intermediate Vision Lenses SV - $10.00
	  ▪ Intermediate Vision Lenses MF - $12.50
	  ▪ Standard Progressives SV and MF - $8.00
	  ▪ Premium Progressives (Varilux®, etc.) SV and MF - $20.00
	  ▪ Photochromic Glass Lenses SV - $10.00
	  ▪ Photochromic Glass Lenses MF - $10.00
	  ▪ Plastic Photosensitive Lenses (Transitions®) - $15.00
	  ▪ Polarized Lenses SV - $15.00
	  ▪ Polarized Lenses BF - $17.50
	  ▪ Polarized Lenses TF - $20.00
	  ▪ Polarized Lenses PAL - $22.50
	  ▪ Standard Anti-Reflective (AR) Coating - $5.00
	  ▪ Premium AR Coating - $9.00
	  ▪ Ultra AR Coating - $25
	  ▪ Hi-Index Lenses SV - $20.00
	  ▪ Hi-Index Lenses MF - $25.00

Benefit	Benefit Limitations/Criteria
	▪ The applicable diagnosis must be listed on the claim and noted in the member's chart.
Polycarbonate Lens	▪ 2 units every year.
Lens Replacement	▪ 2 units every year if lost, stolen or damaged when medically necessary.
Contact Lenses	▪ $130 allowance in lieu of frame and lenses every year. ▪ Allowance may be applied toward the cost of evaluation, materials, fitting and follow-up care. ▪ Expenses in excess of $130 are payable by member. ▪ **Contact lenses must be supplied by the provider.**

Necessary Contact Lenses	▪ Covered as needed when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of:
	  ▪ Aphakia
	  ▪ Keratoconus
	  ▪ Anisometropia that is greater than or equal to 4.00 diopter
	  ▪ Pseudophakia
	  ▪ If the patient has had cataract surgery or implant, or corneal transplant surgery
	  ▪ If visual activity is not correctable to 20/40 in the worse eye by use of spectacle lenses in a frame but can be improved to 20/40 in the worse eye by use of contact lenses
	▪ **Contact lenses must be supplied by the provider.**

Non-Covered Services	▪ Surgical eye care.

1.3 Covered Benefits – UnitedHealthcare Community Plan for Families Ages 20 and Under (Medicaid)

Benefit Plan(s): UDPAM-20

Benefit	Benefit Limitations/Criteria
Exam	▪ 2 service dates every year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Frame	▪ 2 units every year. **1 unit maximum per date of service.** ▪ Frames may be selected from the March frame kit **OR** a $20 retail allowance may be used at retail locations* toward any frame in the selection. To identify frames within the retail location selection, please bill using modifier code 75 in conjunction with service code V2020.
Frame Replacement	▪ Covered as needed if lost, stolen or damaged.
Lens (Single, Bifocal, Trifocal)	▪ 4 units every year. **2 unit maximum per date of service.** ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. Provider is responsible for the cost of traceable shipping of a non-March frame to the March lab for lens fabrication.** ▪ The applicable diagnosis must be listed on the claim and noted in the member's chart.
Polycarbonate Lens	▪ 4 units every year.
Lens Replacement	▪ Covered as needed if lost, stolen or damaged.
Contact Lenses	▪ 1 pair of soft daily wear contact lenses are covered in lieu of frame and lenses every year. ▪ **Contact lenses must be supplied by the provider.**

Necessary Contact Lenses	▪ Covered as needed when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of:
	  ▪ Unilateral Aphakia
	  ▪ Keratoconus when vision with glasses is less than 20/40
	  ▪ Corneal transplant when vision with glasses is less than 20/40
	  ▪ Anisometropia that is greater than or equal to 4.00 diopter
	▪ **Contact lenses must be supplied by the provider.**

Non-Covered Services	▪ Surgical eye care.

* Retail locations include chain stores such as Wal-Mart. The $20 allowance does not apply at independent provider offices or optical locations.

1.4 Covered Benefits – UnitedHealthcare Community Plan for Families Ages 21 and Older (Medicaid)

Benefit Plan(s): UDPAM-21

Benefit	Benefit Limitations/Criteria
Exam	▪ 2 service dates every year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Frame	▪ 1 unit every year. ▪ Frames may be selected from the March frame kit **OR** a $20 retail allowance may be used at retail locations* toward any frame in the selection. To identify frames within the retail location selection, please bill using modifier code 75 in conjunction with service code V2020.
Lens (Single, Bifocal, Trifocal)	▪ 2 units every year. ▪ **Lenses must be provided by the March lab. Please refer to Exhibit D in the Provider Reference Guide for lab information. Provider is responsible for the cost of traceable shipping of a non-March frame to the March lab for lens fabrication.** ▪ The applicable diagnosis must be listed on the claim and noted in the member's chart.
Polycarbonate Lens	▪ 2 units every year for members who are blind in one eye and/or have a prescription greater than +/- 6.00.
Lens Replacement	▪ Covered as needed age 20 and under if lost, stolen or damaged.
Contact Lenses	▪ 1 pair of soft daily wear contact lenses are covered in lieu of frame and lenses every year. ▪ **Contact lenses must be supplied by the provider.**

Necessary Contact Lenses	▪ Covered as needed when such lenses provide better management of a visual or ocular condition than can be achieved with spectacle lenses, including, but not limited to the diagnosis of:
	  ▪ Unilateral Aphakia
	  ▪ Keratoconus when vision with glasses is less than 20/40
	  ▪ Corneal transplant when vision with glasses is less than 20/40
	  ▪ Anisometropia that is greater than or equal to 4.00 diopter
	▪ **Contact lenses must be supplied by the provider.**

Non-Covered Services	▪ Surgical eye care. ▪ Replacements.

* Retail locations include chain stores such as Wal-Mart. The $20 allowance does not apply at independent provider offices or optical locations.

1.5 Covered Benefits – UnitedHealthcare Dual Complete® PA-S002 (Medicare) H3113-009

Benefit Plan(s): UDPA-DSNP

Benefit	Benefit Limitations/Criteria
Exam*	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Eyewear*	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.6 Covered Benefits – UnitedHealthcare Dual Complete® PA-V001 (Medicare) H3113-014

Benefit Plan(s): UDPA-DSNP3

Benefit	Benefit Limitations/Criteria
Exam*	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Eyewear*	▪ $250 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.7 Covered Benefits – UnitedHealthcare Dual Complete® PA-S001 (Medicare) H1889-007

Benefit Plan(s): UDPA-DSNP4

Benefit	Benefit Limitations/Criteria
Exam*	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Eyewear*	▪ $300 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.8 Covered Benefits – UnitedHealthcare Dual Complete® PA-S3 (Medicare) H3113-016

Benefit Plan(s): UDPA-DSNP5

Benefit	Benefit Limitations/Criteria
Exam*	▪ 1 service date every calendar year.
Necessary Medical Services	▪ Medical services covered when medically necessary and performed by an optometrist with the scope of licensure. Individual medical policies can be found at the following link: Provider Reference Guide (marchvisioncare.com).
Eyewear*	▪ $200 allowance every calendar year. ▪ Allowance may be used toward frames, lenses, lens extras and contact lenses. ▪ In-house frame and lenses **MUST** be used.
Eyewear After Cataract Surgery	▪ One pair of eyeglasses (standard frame and lenses) OR one pair of contact lenses per lifetime, per eye after cataract surgery. ▪ Allowance does not apply and may not be used towards extras. Any add on items will be denied.
Glaucoma Screening	▪ 1 service date every calendar year when member is considered “at-risk” according to the following Medicare definitions of “at-risk”: ▪ Individuals with a family history of glaucoma ▪ Individuals with diabetes mellitus ▪ African-Americans ages 50 and older ▪ Hispanic-Americans ages 65 and older
Non-Covered Services	▪ Surgical eye care

1.9 Medicaid Reimbursement Procedures

The UnitedHealthcare Community Plan for Kids (CHIP) benefit affords members the opportunity to:

- Select a frame from the March frame kit, OR
- Select a frame from the provider's selection using a $130 allowance, OR
- Select contact lenses in lieu of frame and lenses using a $130 allowance.

The following examples illustrate reimbursement for each scenario. These examples are for illustrative purposes only and may not reflect actual amounts.

March Frame Kit

Providers must bill the current and appropriate service code for the fitting of spectacles. Reimbursement for the fitting of spectacles will be at the lesser amount of billed charges or the provider's contracted rate. Frame and lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following example assumes a contracted rate of $10 for the fitting of spectacles.

Service Code	Description	Modifier	Billed Charges	Paid Amount
92340	Fitting of Spectacles		$ 25.00	$ 10.00
Total			**$ 25.00**	**$ 10.00**

Retail Allowance - Frame

Providers must bill the current and appropriate service code for frames with modifier code 75. Reimbursement for frames will be at the lesser amount of billed charges or the provider's contracted rate. The contracted rate is $65. Lens codes are not reimbursable and should not be billed as materials are provided by the March lab.

The following examples assume a $130 retail allowance and a contracted rate of $65 for frames when members choose a frame using the retail allowance.

Example 1

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 150.00*	$ 65.00
92340	Fitting of Spectacles**		$ 25.00	$ 0.00
Total			**$ 175.00**	**$ 65.00**

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for $20.
**Fitting of Spectacles is not reimbursable when frames are dispensed from the provider's selection. This fee is not billable to the member.

Example 2

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2020	Frame	75	$ 50.00*	$ 50.00
92340	Fitting of Spectacles**		$ 25.00	$ 0.00
Total			**$ 75.00**	**$ 50.00**

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for $0.
**Fitting of Spectacles is not reimbursable when frames are dispensed from the provider's selection. This fee is not billable to the member.

In all instances, providers are required to use the March lab for lenses. Providers will be responsible for the cost of traceable shipping of non-March frames to the March lab for lens fabrication. This cost is not billable to the member nor can it be deducted from the member's allowance.

Retail Allowance – Contact Lenses

Providers must bill the current and appropriate HCPCS code(s) for contact lenses and CPT code for contact lens fitting. Reimbursement will be at billed charges up to $130.

Example 1

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 100.00*	$ 100.00
92310	Contact Lens Fitting	75	$ 25.00*	$ 25.00
Total			**$ 125.00**	**$ 125.00**

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for $0.

Example 2

Service Code	Description	Modifier	Billed Charges	Paid Amount
V2500	Contact Lenses	75	$ 150.00*	$ 130.00
92310	Contact Lens Fitting	75	$ 25.00*	$ 0.00
Total			**$ 175.00**	**$ 130.00**

*Member is responsible for charges exceeding their benefit allowance. In this example, the member is responsible for $45.

March may modify the Provider Services Agreement, the Provider Policies or any other contract, policy or procedure affecting Providers or the provision or payment of health care services to Members, only upon at least 30 days prior written notice unless the change is required by law or regulation.

1.10 State Mandated Contract Provisions

Definitions

Department	The Department of Human Services (DHS) of the Commonwealth of Pennsylvania.
HealthChoices Program	The Pennsylvania 1915(b) waiver program to provide mandatory managed health care to Recipients.
HealthChoices Zone (HC Zone)	A multiple-county area in which the HealthChoices Program has been implemented to provide mandatory managed care to Medicaid Recipients in Pennsylvania.
Medical Assistance (MA)	The Medical Assistance Program authorized by Title XIX of the Federal Social Security Act, 42 U.S.C. 1396 et seq., and regulations promulgated thereunder, and 62 P.S. and regulations at 55 PA Code Chapters 101 et seq.
Provider	A person, firm or corporation, enrolled in the Pennsylvania MA Program, which provides services or supplies to Recipients.
Recipient	A person eligible to receive physical and/or behavioral health services under the MA program of the Commonwealth of Pennsylvania.

Recipient Restriction Program; Provider IDs

Provider shall cooperate with the Health Plan's and the Department's Recipient Restriction Program, if any. Provider must be enrolled in the Commonwealth's MA Program and possess an active PROMISe™ provider ID.

Pennsylvania Integrated Delivery System-Provider Requirements

To the extent that the Pennsylvania Department of Health determines that the arrangement between the Health Plan, March Vision Care, and/or Provider constitutes an arrangement between a plan and an Integrated Delivery System ("IDS" as such term is defined in 28 Pa. Code Section 9.602), the following provisions apply as required by 28 Pa. Code Section 9.725:

1. The Parties agree to comply with the IDS standards set forth in 28 Pa. Code Section 9.723-9.725, including the requirements set forth in this Exhibit. In the event of a material conflict between a term or provision contained in this Exhibit and a term or provision elsewhere in the participation agreement, this Exhibit shall control as to the Parties' duties and obligations regarding Members receiving services pursuant to the contractual arrangement between the Health Plan and March Vision Care.
2. Participating Provider (collectively hereinafter "Provider") acknowledges and agrees that nothing in the participation agreement limits:
    (a) The authority of the Health Plan to ensure Provider's participation in and compliance with the Health Plan's quality assurance, utilization management, enrollee complaint and grievance systems and procedures or limits;
    (b) The Pennsylvania Department of Health's authority to monitor the effectiveness of the Health Plan's system and procedures and the extent to which the Health Plan adequately monitors any function delegated to March Vision Care, or to require the Health Plan to take prompt corrective action regarding quality of care or Member grievances and complaints; or
    (c) The Health Plan's authority to sanction or terminate a Provider found to be providing inadequate or poor quality care or failing to comply with plan systems, standards or procedures as agreed to by March Vision Care.
3. Provider acknowledges and agrees that any delegation by the Health Plan to March Vision Care for performance of quality assurance, utilization management, credentialing, provider relations and other medical management systems shall be subject to the Health Plan's oversight and monitoring of March Vision Care's performance.
4. Provider acknowledges and agrees that the Health Plan, upon failure of March Vision Care to properly implement and administer the systems, or to take prompt corrective action after identifying quality, enrollee satisfaction or other problems, may terminate its contract with March Vision Care, and that as a result of the termination, Provider's participation in the Health Plan's programs may also be terminated.
5. Neither March Vision Care nor Providers shall in any event, including, but not limited to the failure, denial or reduction of payment by the Health Plan, insolvency of the Health Plan or breach of the participation agreement, bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or person acting on their behalf (other than the Health Plan) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges, if any, made in accordance with the terms of the applicable plan. March Vision Care further agrees that this section: (a) shall survive the expiration or termination of the participation agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between March Vision Care and Members or person acting on their behalf.

Member Hold Harmless

Provider shall not, in any event, including, but not limited to the failure, denial or reduction of payment by Company, insolvency of Company or breach of this Agreement, bill, charge, collect a deposit from, seek remuneration or reimbursement from, or have any recourse (i) against Members or person acting on their behalf (other than Company) or (ii) any settlement fund or other res controlled by or on behalf of, or for the benefit of, a Member for Covered Services. This provision shall not prohibit collection of Copayments, Coinsurance, Deductibles or other supplemental charges, if any, made in accordance with the terms of the applicable plan. Provider further agrees that this section: (a) shall survive the expiration or termination of this Agreement regardless of the cause giving rise to termination and shall be construed for the benefit of Members; and (b) supersedes any oral or written contrary agreement or waiver now existing or hereafter entered into between Provider and Members or person acting on their behalf.

Fraud and Abuse

Provider is notified of the Pennsylvania Medical Assistance Provider Self Audit Protocol which allows Providers to voluntarily disclose overpayments or improper payments of MA funds. The protocol is available on the Department's Web site at www.dhs.pa.gov under "Fraud and Abuse." Provider has been notified of the prohibitions and sanctions for the submission of false claims and statements, and acknowledges it may be subject to sanctions in connection with violations of Federal and state laws and regulations (including, without limitation, statutes and regulations related to fraud, abuse, discrimination, disabilities, confidentiality, false claims and prohibition of kickbacks) related to the agreement between Provider and March Vision Care, the services to be provided hereunder, and the submission of claims and statements.

No Gag Clause

Provider is not subject to any gag clause which limits Provider or its employees or agents from disclosing information pertaining to the HealthChoices Program in accordance with Applicable Law.

Additional Pennsylvania Requirements

The Provider Services Agreement may not contain provisions permitting March to sanction, terminate or fail to renew a Provider's participation for any of the following reasons:

- Advocating for medically necessary and appropriate health care services for a Member.
- Filing a grievance on behalf of and with the written consent of a Member, or helping a Member to file a grievance.
- Protesting a March decision, policy or practice the Provider believes interferes with its ability to provide medically necessary and appropriate health care.

Taking another action specifically permitted by 40 P.S. §§ 991.2113, 991.2121 and 991.2171.

The Provider Services Agreement may not contain any provision permitting March to penalize or restrict a Provider from discussing any of the information Providers are permitted to discuss under 40 P.S. § 2113 or other information the Provider reasonably believes is necessary to provide to a Member concerning the health care of the Member.

Member records shall be kept confidential by March and the health care provider in accordance with 40 P.S. §2131 and all applicable state and federal laws and regulations. DOH and, when necessary, the Department of Human Services shall have access to records for the purpose of quality assurance, investigation of complaints or grievances, enforcement or other activities related to compliance with Article XXI, 28 Pa. Code, Chapter 9, and other laws of Pennsylvania. Such records are only accessible to Department employees or agents with direct responsibilities related to the above matters.

Notwithstanding anything in the Provider Services Agreement to the contrary, March shall pay a clean claim submitted by a Provider within forty-five (45) days of receipt of the clean claim. If March fails to remit the payment as provided above, interest at ten percent (10%) per annum shall be added to the amount owed on the clean claim. Interest shall be calculated beginning the day after the required payment date and ending on the date the claim is paid. March shall not be required to pay any interest calculated to be less than two dollars ($2).

Notwithstanding anything in the Provider Services Agreement to the contrary, neither March nor a Provider shall be permitted to terminate a Provider Services Agreement upon less than sixty (60) days prior written notice.

The Provider Services Agreement shall not contain any incentive reimbursement system for Providers that weighs utilization performance as a single component more highly than quality of care, Member services and other factors collectively.

1.11 Complaint and Grievance Procedures

Your office is required to cooperate with our Policies and Procedures March shall have access to office records and such information obtained from the records shall be kept confidential.

Your office is required to comply with March's requests for patient records within five business days of receiving the request. If your office does not cooperate with the grievance investigation by submitting requested records, your right to appeal will be considered waived. Your office may not charge March or the patient for any cost associated with documentation or duplication of materials involved in a grievance investigation. These obligations shall survive the contractual relationship between March and your office.

You have the right to appeal any determination made by March as the result of a grievance investigation. Appeals should be in writing and mailed within 45 days after you receive the determination to:

March Vision Care
6701 Center Drive West, Suite 790
Los Angeles, CA 90045

Complaint/Grievance/Fair Hearings Process Medicaid and CHIP	
Member Complaint Definition	**Complaint:** A dispute or objection regarding a participating Health Care Provider or the coverage, operations, or management policies of a Managed Care Plan which has not been resolved by the Managed Care Plan and has been filed with the Plan or the Pennsylvania Department of Health or the Department of Human Services. The term does not include a Grievance. A complaint may be communicated verbally or in writing.
Special Consideration	The member must file the complaint within **forty-five (45)** days from the date of the incident complained of or the date the member receives written notice of the decision. ▪ If the complaint is received beyond the **forty-five (45) day** timeframe, the member will be mailed a filed beyond the timeframe letter within **five (5) business days.** ▪ The member may participate in the Committee review either telephonically or in person. If the member cannot appear in person an opportunity to communicate with the review Committee will be made by phone. If the member chooses not to attend the meeting it will be conducted with the same protocols as if the member was present. If the member elects to participate in the complaint review, accepts the review date and time, but does not attend, the committee review must be conducted with the same protocols as if the member was present. **<u>The Managed Care Plan will provide:</u>** ▪ Assistive service for members with disabilities in presenting their case at the complaint review at no cost to the member. ▪ Qualified sign language interpreters, TTY/TDD for telephone inquiries or other commonly accepted alternative forms of communication. ▪ Information to support the Managed Care Plan's stance in a format that the member can understand to discuss and /or refute. ▪ Assistance in copying and presenting documents and other evidence for review by the Managed Care Plan. ▪ Appropriate plan staff to assist the member with the complaint process ▪ Language interpreter service when requested by a member at no cost to the member. ▪ Reasonable opportunity for the member to present evidence and allegations of fact or law in person as well as in writing with accommodations provided by the Managed Care Plan whether by telephone or in person.
Member Representation	A member or the member representative, who may include the member's provider, may file a complaint in writing or orally through the Managed Care Plan's Call Center. All representatives of the member must provide proof of the member's written authorization for the representative to be involved and/or act on the member's behalf.

	▪ A member who consents to the filing of a complaint by a health care provider may not file a separate complaint. The member retains the right to rescind consent throughout the complaint process upon written notice to the Managed Care Plan and the provider. In order for the Provider to represent the member in the conduct of a complaint, the provider must obtain the written consent of the member. A provider may obtain the member's written permission at the time of treatment. A provider may NOT require a member to sign a document authorizing the provider to file a complaint as a condition of treatment. The written consent must include: ▪ The name and address of the member, the member's date of birth and identification number; ▪ The name, address and NPI number of the provider to whom the member is providing consent; ▪ The name and address of the plan to which the grievance will be submitted; ▪ An explanation of the specific service/item for which coverage was provided or denied to the enrollee to which the consent will apply; and ▪ The following statement: "The member or the member's representative may not submit a complaint or grievance concerning the services/items listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or the member's representative has the right to rescind consent at any time during the complaint or grievance process.
Resolution/ Decision Timeframes	**Complaints will be resolved in the following timeframes:** ▪ Expedited within forty-eight (48) hours ▪ 1st Level within thirty (30) calendar days ▪ 2nd Level within forty-five (45) calendar days
Complaint Process	
First Level Complaint Process	▪ The member and the member's representative (if designated), will be mailed an acknowledgement letter with the date of the complaint closure so that the member will have the opportunity to submit verbally or in writing more information on their behalf up to **fifteen (15) calendar days** prior to the complaint closure date. ▪ The member will be contacted and the issue will be clarified with the member. If the Managed Care Plan is unable to contact the member, documentation for review will be investigated with information available with attention to closure date. ▪ Review will be completed with a decision rendered as quickly as the member's health condition requires but no more than **thirty (30) calendar days** from receipt of the complaint. ▪ The member may request an extension by **fourteen (14) calendar days.** **Decision:** ▪ Complaints involving a clinical issue will be reviewed by a physician in the same or similar specialty that typically manages or consults on the service/item in complaint. Other appropriate providers may participate in the review, but the licensed physician will decide the complaint. ▪ The Managed Care Plan will mail written determination letter to the member and/or designated member representatives, service provider and prescribing PCP, if applicable, of the first level complaint review decision within **five (5) business days** of the Committee's decision. ▪ Notify March of the decision and verify that the actions requested are completed; **Member's Rights:**

	▪ Follow the directions in the decision letter. ▪ May file a 2nd level complaint within **forty-five (45) calendar days** from the date of the decision letter. ▪ May file for a Fair Hearing within **thirty (30) calendar days** from the date on the written notice of the decision (Medicaid Members Only; excludes CHIP Members) ▪ Withdraw a previously filed Fair Hearing.
Second Level Complaint Process	▪ The member and the member's representative (if designated), will be mailed an acknowledgement letter upon receipt indicating the 2nd Level Committee meeting date, procedures (the date, time and place of the meeting) as well as their rights and responsibilities. The member will have the opportunity to submit verbally or in writing more information on their behalf up to **fifteen (15**) **calendar days** prior to the complaint closure date. ▪ The member will be contacted and the issue will be clarified with the member. If unable to contact the member, documentation for review will be investigated with information available with attention to closure date. ▪ The member will be contacted confirming the date at least **fifteen (15) calendar days** prior to the meeting date. **The 2nd Level Committee will:** ▪ The second level review committee will consist of three (3) individuals, two (2) of which are Managed Care Plan staff, who were not involved in any previous level of review or decision-making on the issue under review. ▪ A licensed physician as appropriate in the same or similar specialty that typically manages or consults on the health care service under review. ▪ Committee proceedings shall be informal and impartial. ▪ Committee members are not to discuss the case prior to the review meeting, must actively participate in the review by attending in person or by conference call; must review information introduced prior to the vote. ▪ All persons attending and their respective roles will be identified. **Decision:** ▪ A decision will be rendered within **forty-five (45) calendar days** from receipt of the member's 2nd Level Complaint. ▪ The decision will be based solely on the information presented. ▪ Testimony will be tape-recorded and a summary prepared or transcribed verbatim and placed in the complaint file. ▪ The member and the member's representative (if designated) will be mailed the decision within **five (5) business** days. **Member Rights:** ▪ Follow the directions in the decision letter. ▪ File an **external review** with either Department of Health or the Department of Human Services within **fifteen (15) days** from receipt of the decision letter. ▪ File a Fair Hearing within **thirty (30) calendar days** from the date on the written notice of the decision. (Medicaid Members Only; excludes CHIP Members) ▪ Withdraw previously filed Fair Hearing.
External Review of 2nd Level Complaint Review Decision	Upon request to either DOH or DHS for external review of the 2nd level Complaint Review Decision: ▪ All records from 1st and 2nd level review will be copied and mailed to the appropriate Department within **thirty (30) calendar days** from the request. **Decision:** DOH or DHS will make a determination and notify the member, health care provider and Managed Care Plan of the decision.

	▪ March will be notified of the decision and action requested and verify that the actions requested are complete.
Member Grievance Definition	**Grievance:** A request by an enrollee or a health care provider, with written consent of the enrollee, to have the managed care plan or utilization review entity reconsider a decision solely concerning medical necessity and appropriateness of health care services. The term does not include a Complaint. If the managed care plan is unable to resolve the matter, a Grievance may be filed regarding a decision that will: ▪ Deny, in whole or in part, payment for a service/item if based on lack of medical necessity. ▪ Deny or issue a limited authorization of a requested service/item, including the type or level of service/item. ▪ Reduce, suspend, or terminate a previously authorized service/item. ▪ Deny the requested service/item but approve an alternative service/item. **Pre-service grievance** is a request to change an adverse determination for care or service that the organization must approve, in whole or in part, in advance of the member obtaining care or services. **Post-service grievance** is a request to change an adverse determination for care or services that have already been received by the member. For the above definition points the Member will be given **forty-five (45) calendar days** from the date the member receives the written notice to file a grievance. The Managed Care Plan may extend the filing time frame by **14 calendar days** for the following reasons: ▪ The member was seriously ill which prevented timely filing. ▪ There was a death or serious illness in the member's immediate family. ▪ An accident caused important records to be destroyed. If the grievance is received beyond the **forty-five (45) calendar day** timeframe, and does not meet the criteria listed above, Managed Care Plan will mail the member a filed beyond the timeframe letter within **five (5) business days.**
Special Consideration	**For All Levels of Grievances:** ▪ A member who files a grievance to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the grievance, if the grievance is hand delivered or post-marked within ten (10) days from the date on the written notice of decision. Health services, dental and pharmacy departments will be notified once the request is made and the timeline is verified that it is within ten (10) days to continue services and document in the file ▪ The member may participate in the Committee review either telephonically or in person. If the member cannot appear in person an opportunity to communicate with the review Committee will be made by phone. If the member chooses not to attend the meeting it will be conducted with the same protocols as if the member was present. If the member elects to participate in the grievance review, accepts the review date and time, but does not attend, the committee review must be conducted with the same protocols as if the member was present. **Managed Care Plan will provide:** ▪ Assistive service for members with disabilities in presenting their case at the grievance review at no cost to the member ▪ Qualified sign language interpreters, TTY/TDD for telephone inquiries or other commonly accepted alternative forms of communication ▪ Information to support Managed Care Plan's stance in a format that the member can understand to discuss and /or refute

	▪ Assistance in copying and presenting documents and other evidence for review by Managed Care Plan ▪ Appropriate plan staff to assist the member with the grievance process ▪ Language interpreter service when requested by a member at no cost to the member ▪ Reasonable opportunity for the member to present evidence and allegations of fact or law in person as well as in writing with accommodations provided by Managed Care Plan whether by telephone or in person.
Member Representation	A member or the member representative, who may include the member's provider, may file a grievance in writing or orally through the Member Helpline. All representatives of the member must provide proof of the member's written authorization for the representative to be involved and/or act on the member's behalf. ▪ A member who consents to the filing of a grievance by a health care provider may not file a separate grievance. The member retains the right to rescind consent throughout the Grievance process upon written notice to Managed Care Plan and the provider In order for the Provider to represent the member in the conduct of a grievance, the provider must obtain the written consent of the member. A provider may obtain the member's written permission at the time of treatment. A provider may NOT require a member to sign a document authorizing the provider to file a grievance as a condition of treatment. Managed Care Plan will ensure that no punitive action is taken against a provider who either requests an expedited resolution of a grievance or supports a member's request for expedited review of a grievance or acts on behalf of the member. The written consent must include: ▪ The name and address of the member, the member's date of birth and identification number; ▪ The name, address and NPI number of the provider to whom the member is providing consent; ▪ The name and address of the plan to which the grievance will be submitted; ▪ An explanation of the specific service/item for which coverage was provided or denied to the enrollee to which the consent will apply; and ▪ The following statement: "The member or the member's representative may not submit a complaint or grievance concerning the services/items listed in this consent form unless the member or the member's representative rescinds consent in writing. The member or the member's representative has the right to rescind consent at any time during the complaint or grievance process.
Resolution/ Decision Timeframes	**Grievances will be resolved in the following timeframes:** ▪ Expedited within forty-eight (48) hours ▪ 1st Level within thirty (30) calendar days ▪ 2nd Level within forty-five (45) calendar days
Grievance Process	
First Level Grievance Process	▪ The member and member's representative will be mailed an acknowledgement letter upon receipt that will indicate the date of the grievance closure so that the member will have the opportunity to submit verbally or in writing more information on their behalf up to **fifteen (15) calendar days** prior to the grievance closure date. ▪ The member will be contacted and the issue will be clarified with the member. If unable to contact the member, documentation for review will be investigated with information available with attention to closure date. ▪ The review will be completed with a decision rendered as quickly as the member's health condition requires, but no more than **thirty (30) calendar days** from receipt of the grievance. ▪ The member may request an extension by **fourteen (14) calendar days.**

	Decision: ▪ A licensed physician and an approved licensed optometrist or designee, in the same or similar specialty as that which would typically manage or consult on the health care service/item in question, will review the case. An optometrist and a licensed physician will review vision cases. ▪ Managed Care Plan will mail determination of the decision to the member, the member's representative, if the member has designated one, service provider and prescribing PCP if applicable within **five** (**5) business day**s from the decision. ▪ March will be notified of the decision and verify the actions requested are completed. **Member's Rights:** ▪ Follow the directions in the decision letter. ▪ File 2nd Level Grievance within **forty-five (45) calendar days** from receipt of the determination letter. ▪ File a Fair Hearing within **thirty (30) calendar days** from the date on the determination letter. (Medicaid Members Only; excludes CHIP Members) ▪ File an Expedited Grievance. ▪ Withdraw a previously filed Fair Hearing.
Second Level Grievance Process	▪ The member and the member's representative (if designated), will be mailed an acknowledgement letter upon receipt indicating the 2nd Level Committee meeting date, procedures (the date, time and place of the meeting) as well as their rights and responsibilities. The member also can submit verbally or in writing more information on their behalf up to **fifteen (15) calendar days** before the grievance closure date. ▪ The member will be contacted and the issue will be clarified with the member. If unable to contact the member, documentation for review will be investigated with information available with attention to closure date. **Second Level Review Committee:** ▪ The second level review committee will consist of three (3) individuals, two (2) of which are Managed Care Plan staff, who were not involved in any previous level of review or decision making to deny coverage or payment for the requested service/item under review. ▪ Include a licensed physician, as appropriate, in the same or similar specialty that typically manages or consults on the service/item under review. Other appropriate providers may participate in the review. ▪ Committee proceedings shall be informal and impartial. ▪ All persons attending and their respective roles will be identified. ▪ Committee members are not to discuss the case prior to the review meeting, must actively participate in the review by attending in person or by conference call; must review information introduced prior to the vote. ▪ Include a QM designated staff person. **Decision**: ▪ Rendered within **forty-five (45) calendar days** from receipt of the member's 2nd Level Grievance ▪ Will be based solely on the information presented ▪ Testimony will be tape-recorded and a summary prepared or transcribed verbatim and placed in the grievance file ▪ The decision will be mailed to the member within **five (5) business** days ▪ March will be notified of the decision and verify the actions requested are completed **Member's Rights:**

	▪ Follow the directions in the decision letter. ▪ File an external review of the 2nd Level Grievance **within fifteen (15) calendar days** from receipt of the decision letter to the Dept of Health. ▪ File a Fair Hearing within thirty **(30) calendar days** from the date of the decision letter. (Medicaid Members Only; excludes CHIP Members) ▪ Withdraw a previously filed Fair Hearing.
External Review of Second Level Grievance Decision	An external grievance can only be requested following completion of the internal grievance process. ▪ The member and the Department of Health (DOH) will be mailed the notification within **five (5) business days** that a request for external grievance review has been filed. The letter to the DOH must request a Certified Utilization Review Entity (CRE) to conduct the grievance. **Within fifteen (15) calendar days of receipt of the appeal request:** ▪ The member will be mailed and will proof a list of documents forwarded to the CRE along with a statement that the member may supply additional information to the CRE conducting the external grievance review for consideration. The member must also forward a copy of any additional information to the Managed Care Plan so the Managed Care Plan has the opportunity to consider the information. ▪ Managed Care Plan will mail copies of all documentation within the 1st and 2nd Level Grievance files to the CRE conducting the external grievance review. **CRE Protocol:** ▪ DOH will assign a certified utilization review entity (CRE) to conduct the review within **two (2) business days** from receipt of the request. ▪ If the Department of Health (DOH) fails to select a CRE **within two (2) business days** from receipt of the request, Managed Care Plan may designate a CRE to conduct a review from the list of CREs approved by the DOH. ▪ Managed Care Plan or the Member has **seven (7) business days** to object to the appointed CRE and a second CRE will be appointed. **Decision:** ▪ The CRE will mail a written decision within **sixty (60) days** from the filing of the request to Managed Care Plan, the member, the member's representative and the provider (if the provider filed the grievance with the member's consent), that includes the basis and clinical rationale for the decision. **Member's Rights:** ▪ Follow the directions in the decision letter. The external grievance decision shall be subject to appeal to a court of competent jurisdiction within **sixty (60) calendar days** from the date the member receives notice of the external grievance decision.
Expedited Grievance Process	It is the member's responsibility to provide Managed Care Plan with their Provider's certification that the member's life health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular grievance process. ▪ The Provider's certification **must** include the Provider's signature. ▪ If the Provider certification is not included with the request for an expedited review, Managed Care Plan will inform the Member that the Provider must submit a certification as to the reasons why the expedited review is needed. ▪ Managed Care Plan will make a reasonable effort to obtain the certification from the Provider. ▪ Members can request an expedited review at any point in the grievance process. ▪ The limited timeframe is **forty-eight (48) hours**;

	The expedited review process is bound by the same rules and procedures as the second level grievance review process with the exception of time frames. ▪ If the Second Level Grievance Committee is physically unable to be present at the review, the Managed Care Plan will hold the hearing telephonically and all information presented is to be read into the record. ▪ A Committee member who does not attend the review may not vote on the case unless he or she actively participates by telephone, and has the opportunity to review any additional information introduced at the review meeting prior to the vote. ▪ Once the certification is received, all documentation will be presented and decided by a physician in the same or similar specialty that typically manages/ consults on the service/item in question and who has not been involved in any previous level of review or decision making on the issues disputed. The decision will be made within **forty-eight (48) hours** from receiving the provider's certification and the member's request. **Decision:** ▪ The member will be notified by phone of the decision. ▪ The member will be mailed a determination letter within **two (2) days** of the decision that includes the basis for the decision. ▪ Health services/dental or pharmacy will be notified of the decision and verify that the actions requested are completed. **Member's Rights:** ▪ Follow the directions in the decision letter. ▪ File a request for an expedited external grievance review with Managed Care Plan within **two (2) business days** from the date the member receives Managed Care Plan's expedited decision. ▪ File a request for a Fair Hearing within **thirty (30) days** from the date of the decision letter. (Medicaid Members Only; NOT CHIP Members). **PROVIDER CERTIFICATION NOT RECEIVED:** If the provider certification is not received **within forty-eight (48) hours,** Managed Care Plan will decide the grievance using the 1st Level timeframes (within **thirty (30) days -** refer to 1st Level Grievance Process). ▪ Member notified by phone that grievance is following the standard process. ▪ Mail the member written decision within **two (2) business days** of the decision to deny expedited review.
Fair Hearing Definition (Excludes CHIP)	The member, or the member's representative, may request a Department of Human Services (DHS) fair hearing within **thirty (30) calendar days** from the date on the initial written notice of decision and within **thirty (30) calendar days** from the date on the written notice of Managed Care Plan's first or second level complaint or grievance notice.
Special Consideration	**For all Levels of Fair Hearings** A member who files a request for a fair hearing to dispute a decision to discontinue, reduce or change a service/item that the member has been receiving must continue to receive the disputed service/item at the previously authorized level pending resolution of the fair hearing, if the request for a fair hearing is hand delivered or post-marked within **ten (10) calendar days** from the date on decision letter. Members do not have to exhaust the complaint or grievance process prior to filing a request for a fair hearing.
Fair Hearing Process	**Member's Rights and Responsibility:**

	▪ The member's request for a fair hearing must include a copy of the written notice of decision that is the subject of the request. Requests must be sent to: **Department of Human Services** **OMAP – HealthChoices Program** **Complaint, Grievance and Fair Hearings** **P.O. Box 2675** **Harrisburg, Pennsylvania 17105-2675** ▪ The Department's decision is based solely on the evidence presented at the hearing. ▪ If the Bureau of Hearings and Appeals has not taken final administrative action within **ninety (90) calendar days** of the receipt of the request for a fair hearing, Managed Care Plan shall follow the requirements at 55 Pa. Code 275.4 regarding the provision of interim assistance upon the request for such by the member. When the member is responsible for delaying the hearing process, the time limit for final administrative action will be extended by the length of the delay attributed to the member (55 Pa. Code 275.4). **Managed Care Plan's Responsibilities:** ▪ Managed Care Plan is a party to the hearing and must be present. The failure of Managed Care Plan to participate in the hearing will not be reason to postpone the hearing. ▪ Managed Care Plan, which may be represented by an attorney, must be prepared to explain and defend the issue on appeal. ▪ Managed Care Plan must provide members, at no cost, with records, reports, and documents, relevant to the subject of the fair hearing. ▪ Managed Care Plan will consult with other appropriate Managed Care Plan staff and investigate the issue. ▪ Advise member by telephone that the services under appeal will continue until the Fair Hearing determination is made. ▪ Notify March of the decision and verify the actions requested are completed when the decision is made. **Decision:** ▪ The Bureau of Hearings and Appeals' adjudication is binding on Managed Care Plan unless reversed by the Secretary of Human Services. Either party may request reconsideration from the Secretary within **fifteen (15) calendar days** from the date of the adjudication. ▪ Only the member may appeal to Commonwealth Court within **thirty (30) calendar days** from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). The decisions of the Secretary and the Court are binding on Managed Care Plan.
Expedited Fair Hearing Process	**Member Rights:** ▪ A request for an expedited fair hearing may be filed by the member or the member's representative, with proof of the member's written authorization for the representative to be involved and/or act on the member's behalf, with the Department either in writing or orally. ▪ Members do not have to exhaust the complaint or grievance process prior to filing a request for an expedited fair hearing. ▪ An expedited fair hearing will be conducted if a member or a member's representative provides the Department with written certification from the member's provider that the member's life, health or ability to attain, maintain or regain maximum function would be placed in jeopardy by following the regular fair hearing process. This certification is necessary even when the member's request for the expedited fair hearing is made orally. The certification must include the provider's signature. ▪ The Provider can submit a written certification OR may participate in the hearing.

	Decision: ▪ The Bureau of Hearings and Appeals has **three (3) business days** from receipt of the member's oral or written request for an expedited review to process final administrative action. ▪ The Bureau of Hearings and Appeals adjudication is binding on Managed Care Plan unless reversed by the Secretary of Human Services. ▪ Either party may request reconsideration from the Secretary within **fifteen (15) calendar days** from the date of the adjudication. Only the member may appeal to Commonwealth Court within **thirty (30) calendar days** from the date of adjudication (or from the Secretary's final order, if reconsideration was granted). ▪ The decisions of the Secretary and the Court are binding on Managed Care Plan. **Provision of and Payment for Services/Items following Decision** If Managed Care Plan or the Bureau of Hearings and Appeals reverses a decision to deny, limit, or delay services/items that were not furnished during the complaint, grievance or fair hearing process, Managed Care Plan must authorize or provide the disputed services/items promptly and as expeditiously as the member's health condition requires. If Managed Care Plan or the Bureau of Hearings and Appeals reverses a decision to deny authorization of services/items, and the member received the disputed services/items during the complaint, grievance or fair hearing process, Managed Care Plan will pay for services/items.

COMMONWEALTH OF PENNSYLVANIA
Department of Human Services

OFFICE OF MEDICAL ASSISTANCE PROGRAMS
Office of Mental Health and Substance Abuse

MANAGED CARE ORGANIZATION (MCO) EXPEDITED COMPLAINT AND GRIEVANCE REVIEW
AND EXPEDITED DEPARTMENT OF HUMAN SERVICES (DHS) FAIR HEARING

Physician Certification Form

If you need assistance completing this form or if you have questions, please contact our Customer Service Department at (844) 916-2724 Monday through Friday, 8:00 am to 5:00 pm local time.

Date Certification Submitted: _____ Date Service Requested: _____

Prescribing Physician Information

Prescribing Physician: _____ Telephone Number: _____

Physician's MA ID: _____ Fax Number: _____

Member Information

Member's Name: _____ Member's MCO Name: _____

Member's Date of Birth: _____ Member's Social Security #: _____

CERTIFICATION IN SUPPORT OF NEED FOR EXPEDITED CONSIDERATION:

Please explain why utilizing the regular MCO complaint or grievance review process or the regular DHS fair hearing process would place the member's life, health or ability to regain maximum function in jeopardy.

You must include the clinical rationale and the facts necessary to support your opinion that the regular timeframe for resolution of a complaint, grievance or fair hearing will jeopardize the member's life, health or ability to regain maximum function.

Enter information below. (Attach additional pages if necessary.)

_____

_____

_____

_____

Physician's Signature: _____

CERTIFICATION SUBMITTED TO SUPPORT:

Expedited Complaint Review ☐ **(Fax to MCO)**

Expedited Grievance Review ☐ **(Fax to MCO)**

Expedited DHS Fair Hearing ☐ **(Fax to MCO)**

NOTE: IF SUBMITTING FOR BOTH EXPEDITED COMPLAINT OR GRIEVANCE **AND** EXPEDITED DHS FAIR HEARING, SUBMIT CERTIFICATION VIA FAX TO BOTH MCO AND DHS.