[Insert Date]

[Member Name]
[Member Street Address]
[City, State Zip]

RE: Member Name: [Member name]
Member DOB: [Member DOB]
Member ID: [Member ID]

Dear [Member name]:

Your inpatient admission was denied
We've reviewed the clinical documentation submitted by your provider for admission to an inpatient acute care facility as listed below. Our review determined that you did not meet InterQual® medical necessity criteria, medical policy, or Medicare guidelines for the requested level of care. The request is denied.

Facility: [Hospital Provider]
Requested Date of Service: [Insert Admission Date]

Why your admission was denied
We denied the medical service listed above because:
[User Content Placeholder – provide specific rationale for decision and include specific criteria or plan document provision to support decision].

When reviewing the individual medical record, Priority Health used additional criteria [User content – Insert IQ Subset] to assess clinical factors documented for the inpatient admission.

Upon request, you or your provider have the right to a copy of the criteria used to make this decision.

If you disagree with this decision, you have certain rights. For your convenience, enclosed is a copy of your plan's appeal process. Participating providers cannot balance bill you for these services.

If your provider would like to discuss this decision, a physician reviewer is available during business hours.

If you have questions, visit priorityhealth.com/contact-us or call the Customer Service number on the back of your member ID card.

Sincerely,

Priority Health Choice

Medical Management

Encl.: appeal process brochure

cc: [HOSPITAL PROVIDER]