Parkland
Community Health Plan, Inc.

[TEMPLATE.DatePrint]

[TEMPLATE.ConvertedMemName]
[TEMPLATE.MemAddr1], [TEMPLATE.MemAddr2]
[TEMPLATE.MemCity, State Zip]

Subject: Prior Authorization Request for Parkland HEALTH*first* Member

Member Name:	[TEMPLATE.MemName]
Member ID:	[TEMPLATE.MemID]
Requesting Provider:	[TEMPLATE.ReferFromName]
Date Request Received:	[TEMPLATE.Referral.ReceiptDate]
Requested Service(s):	[TEMPLATE.FreeFormText]
Requested Date(s) of Service:	[TEMPLATE.Eff Date] - [TEMPLATE.FreeFormText]
Authorization Number:	[TEMPLATE.AuthorizationID]

Dear Parkland HEALTH*first* Member:

We would like to inform you (member or an individual acting on behalf of the member, and the member's provider of record, including the health care provider who rendered the service) of our decision about this request. A doctor looked at all of the records that were sent to us. We also tried to talk to your doctor about the request. Any new information given to us was considered. The doctor who made the decision is Board Certified in [TEMPLATE.FreeFormText].

Decision
The request for [TEMPLATE.FreeFormText] is [TEMPLATE.TemplateType].

The facts do not show that the services are needed to treat your condition. The reason for this decision is:

[TEMPLATE.MedDirClinicalNotes]

Guideline(s) used in making this decision
We use national and/or plan guidelines to help us make our decisions. In this case the criteria we used [Template.FreeFormText].

You can ask for a free copy of the guideline(s). Call the Parkland HEALTH*first* Member Advocate at the number below and we will send you a copy within ten (10) working days.

The doctor who made the request has been told about this decision. The date the decision will take effect is [TEMPLATE.Denial Eff Date]. If you are asking to continue services we have approved before, this is the last day the services will be approved. .

A copy of this letter has been sent to your primary care provider and other providers, if needed. You should call your primary care provider to help with any future requests for health care services.

If you need help getting care (doctor visits, supplies or other services), information about care management services or Case Management for Children and Pregnant Women, please call us and ask to speak to the Parkland HEALTH*first* Member Advocate.

Sincerely,

[TEMPLATE.MMA Init]

Medical Management Department
Parkland Community Health Plan

Enclosures:
Process for Complaint and/or Appeal of Adverse Determination and Requesting a Fair Hearing for Parkland HEALTH*first* Members
Process for Filing a Fair Hearing Request Form
Listing of Legal Service Providers
Nondiscrimination Notice

cc: [TEMPLATE. Refer From Name]
cc: [TEMPLATE. Refer To Name]
cc: [TEMPLATE. PCP Name]
cc: [TEMPLATE.OtherMail]
cc: [TEMPLATE.OtherFax]