

[Insert the sending entity's logo and contact information]

Patient Name: <Member Name>

OMB Approval No. 0938-1019

Patient ID Number: <Member ID>

Date Issued: <Date>

Physician: <Servicing Provider>

Detailed Notice of Discharge

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan), in agreement with your doctor, believe that your inpatient hospital services should end on <date>. This is based on Medicare coverage policies listed below and your medical condition.

This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

- Medicare Coverage Policies:

Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).

Medicare Managed Care policies, if applicable: <insert specific managed care policies (free form)>

Other <insert other applicable policies (free form)>

- Specific information about your current medical condition:
<free form>

- If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call IEHP DualChoice Member Services at 1-877-273-IEHP (4347), 8am – 8pm (PST), 7 days a week, including holidays. TTY/TDD users should call 1-800-718-4347.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a Health Plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



**DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY**

Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact IEHP Member Services at 1-877-273-4347 (TTY: 1-800-718-4347).

If you believe that IEHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
Tel. 1-800-368-1019, (TDD: 800-537-7697). Complaint forms are available at
<http://www.hhs.gov/ocr/office/file/index.html>.



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Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:

- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
 - Intérpretes de lenguaje de señas calificados
 - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)
- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
 - Intérpretes calificados
 - Información escrita en otros idiomas

Si necesita recibir estos servicios, comuníquese con Servicios para Miembros de IEHP al 1-877-273-4347 (TTY: 1-800-718-4347).

Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.



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También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
Tel. 1-800-368-1019, (TDD: 800-537-7697). Puede obtener los formularios de queja en el sitio web: <http://www.hhs.gov/ocr/office/file/index.html>

LANGUAGE ASSISTANCE

English

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-877-273-4347(TTY: 1-800-718-4347).

Español (Spanish)

ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-877-273-4347(TTY: 1-800-718-4347).

ةىبرعلا (ARABIC)

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 1-877-273-4347 (رقم هاتف الصم والبكم: 1-800-718-4347).

Հայերեն (ARMENIAN)

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-877-273-4347(TTY (հեռատիպ)՝ 1-800-718-4347):

繁體中文 (CHINESE)

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-273-4347 (TTY : 1-800-718-4347)。

ىسراف (FARSI)

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-877-273-4347 (TTY: 1-800-718-4347) تماس بگیرید.

हिंदी (HINDI)

ध्यान दें: यदि आप हिन्दी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-877-273-4347(TTY: 1-800-718-4347) पर कॉल करें।



LANGUAGE ASSISTANCE

Hmoob (HMONG)

LUS CEEV: Yog tias koj hais lus Hmoob, muaj kev pab txhais lus hmoob pub dawb rau koj. Hu rau 1-877-273-4347(TTY: 1-800-718-4347).

日本語 (JAPANESE)

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。

1-877-273-4347 (TTY:1-800-718-4347) まで、お電話にてご連絡ください。

ខ្មែរ (KHMER)

ចំណាប់អារម្មណ៍: បើសិនអ្នកនិយាយភាសាខ្មែរ (Khmer) សេវាជំនួយភាសាដោយឥតគិតថ្លៃ គឺមានសំរាប់អ្នក។ ទូរស័ព្ទទៅលេខ 1-877-273-4347 (TTY: 1-800-718-4347)។

한국어 (KOREAN)

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

1-877-273-4347 (TTY: 1-800-718-4347)번으로 전화해 주십시오.

ພາສາລາວ (LAO)

ໄປດຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-877-273-4347(TTY: 1-800-718-4347).

ਪੰਜਾਬੀ (PUNJABI)

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ (Punjabi) ਬੋਲਦੇ ਹੋ, ਤਾਂ ਤੁਹਾਡੇ ਲਈ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਸੇਵਾਵਾਂ ਬਿਲਕੁਲ ਮੁਫਤ ਉਪਲਬਧ ਹਨ।
ਕਿਰਪਾ ਕਰਕੇ 1-877-273-4347(TTY: 1-800-718-4347) 'ਤੇ ਕਾਲ ਕਰੋ।

Русский (RUSSIAN)

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-877-273-4347(елетайп: 1-800-718-4347).

TAGALOG (TAGALOG – FILIPINO)

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-877-273-4347(TTY: 1-800-718-4347).

ภาษาไทย (THAI)

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-877-273-4347 (TTY: 1-800-718-4347).

Tiếng Việt (VIETNAMESE)

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-877-273-4347(TTY: 1-800-718-4347).