Appeal Template for Denial Received by the ABA Provider in Requesting a Single Case Agreement to Start Services

This appeal can be filed by the family or by the ABA provider who is ready to serve the child and is either not an approved Medicaid provider or is an approved Medicaid provider without the licensed professional to supervise the BCBA.

Directions:

First, copy the below template and insert your individual information where you see "XX." Secondly, send your appeal request to your managed care plan. See the contact information below the template.

Appeal Template:

I am filing an appeal for my Medicaid-eligible child, (name and Medicaid number XX). My child was diagnosed with autism spectrum disorder (ASD) by a licensed professional and prescribed applied behavior analysis (ABA) therapy. Since that time, I have been unable to access ABA therapy. The EPSDT federal mandate provides early, periodic, screening, diagnosis, and treatment and applies and requires the state Medicaid agency to cover and ensure my child receives this medically necessary care. Prompt treatment is essential and every day without treatment threatens current and future functioning. We are requesting and are entitled to a qualified ABA provider since it has been XX days/months/years since we were prescribed ABA. We have found an ABA provider to serve our child, but our managed care plan denied the provider's request for a single case agreement. Currently, Medicaid does not offer an adequate and accessible ABA provider network since rolling out coverage for ABA therapy in October 2020. -Family Contact Information XX (Name, Address, Phone, Email, Child name, and Medicaid number)

Contact Information for managed care plans: If no email is listed, consider faxing your appeal.

Aetna Better Health of IL - Email: ILAppealandgrievance@aetna.com, Tel: 866-329-4701, Fax: 877-668-2076, Mail: Aetna Better Health of IL, Attn: Appeals Dept., P.O. Box 81139, Cleveland, OH 44181. Formerly Illinicare Health.

Blue Cross Blue Shield Community Plan – Email: unknown, Tel: 877-860-2837, Fax: 866-643-7069, Mail: BCBS, Attn: Grievance and Appeals Unit, P.O. Box 27838, Albuquerque, NM 87125-9705.

CountyCare (HealthChoice) Health Plan – Email: unknown, Tel: 312-864-8200, Fax: 866-200-5031, Mail: CountyCare Health Plan, Attn: CCH A&G Department, P.O. Box 21153, Eagan, MN 55121. Cook County only.

Humana Health Plan – Email: unknown, Tel: 1-800-787-3311, Fax: 1-855-336-6220, Mail: Attn: Grievance and Appeal Dept., PO Box 14546, Lexington, KY 40512-4546

Meridian Health Plan – Email: unknown, Tel: 866-606-3700, Fax: 312-508-7255, Mail: Meridian Health, Attn: Grievance Coordinator or Appeals, Coordinator, PO box 44287, Detroit, MI 48226.

Molina Healthcare of Illinois - Email: MHI.IL.Appeal@MolinaHealthCare.Com, Tel: 855-687-7861, Fax: 855-502-5128, Mail: Molina of Illinois, Attn: Grievance and Appeals Dept., 1520 Kensington Road Suite 212, Oak Brook, IL 60523.

Youthcare –Contact the case worker with the Illinois Department of Child and Family Services.

Medicaid Only – A Medicaid member not enrolled in managed care can file an appeal at DHS.BAH@Illinois.gov.