

**HEALTHCHOICES BEHAVIORAL HEALTH
PROGRAM**

Appendix AA

**COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF PUBLIC WELFARE**

**Commonwealth of Pennsylvania
HealthChoices Behavioral Health
Program Standards and Requirements – Primary Contractor - County**

**Appendix AA
Final 8/21/03**

**OFFICE OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
DEPARTMENT OF PUBLIC WELFARE
PRIOR AUTHORIZATION REQUIREMENTS
FOR PARTICIPATING BEHAVIORAL HEALTH MANAGED CARE
ORGANIZATIONS
IN THE HEALTHCHOICES PROGRAM**

A. GENERAL REQUIREMENT

The HealthChoices Behavioral Health Managed Care Organizations (BH-MCO) must submit to the Department a written description of their policies and procedures for the prior authorization of services. The BH-MCO may require prior authorization for any services which require prior authorization in the Medical Assistance Fee-for-Service (FFS) Program. The BH-MCO must notify the Department of the FFS authorized services they will continue to prior authorize and the basis for their determinations of medical necessity. The BH-MCO must request the Department's approval to require the prior authorization of any services not currently required to be prior authorized under the FFS Program. For each service to be prior authorized, the BH-MCO must submit for the Department's review and approval the written policies and procedures in accordance with the guidelines described below.

The policies and procedures must:

- be approved by the Department in writing prior to implementation;
- adhere to specifications of the HealthChoices (HC) contract, including applicable policy in Medical Assistance General Regulations, Chapter 1101, the Request For Proposal (RFP) and DPW regulations;
- ensure that physical or behavioral health care is medically necessary and provided in an appropriate, effective, timely, and cost efficient manner;
- adhere to the applicable requirements of The Centers for Medicaid and Medicare Services (CMS) Guidelines for Internal Quality Assurance Programs of Health Maintenance Organizations (HMOs), Health Insuring Organizations (HIOs), and Prepaid Health Plans (PHPs), contracting with Medicaid/Quality Assurance Reform Initiative (QARI);
- include an expedited review process to address those situations when an item or service must be provided on an urgent basis.

Future changes in state and federal law, state and federal regulations, and court cases may require re-evaluation of any previously approved prior authorization proposal. Any deviation from the Department's approved policies and procedures, including time frames for decisions, is considered to be a change and requires a new request for approval. Failure of the BH-MCO to comply may result in sanctions/or penalties by the Department.

The Department defines prior authorization as any review of a service or request for a service, which must be conducted as a condition of the service being delivered. The term prior authorization is understood to include but is not limited to:

- pre-certification;
- concurrent;
- predetermination;
- any other review for the purpose of authorizing services.

The OMHSAS Prior Authorization Review Panel has the sole responsibility to review and approve all prior authorization proposals from the BH-MCOs.

B. GUIDELINES FOR REVIEW

1. Basic Requirements:

a. If the prior authorization is limited to specific populations, the BH-MCO must identify all populations who will be affected by the proposal for prior authorization.

2. Medical Necessity Requirements:

a. The BH-MCO must describe the process to validate medical necessity for:

- covered care and services
- procedures and level of care
- medical or therapeutic items

b. The BH-MCO must identify the source of the criteria used to review the request for prior authorization of services. The criteria must be consistent with the HC RFP definition of medical necessity.

c. Medical necessity criteria used by BH-MCOs must conform to Appendix T of the HC BH RFP.

For BH-MCOs, if the criteria being used are:

- purchased and licensed, the BH-MCO must identify the vendor;
- developed/recommended/endorsed by a national or state health care provider association or society, the BH-MCO must identify the association or society;
- based on national best practice guidelines, the BH-MCO must identify the source of those guidelines;
- based on the medical training, qualifications, and experience of the BH-MCO's Medical Director or other qualified and trained practitioners, the BH-MCO must identify the individuals who will make the medical necessity determinations.

d. The BH-MCO must identify the qualifications of staff who will determine medical necessity. Medical necessity determinations must be made by qualified and trained practitioners with appropriate clinical experience or expertise in treating the member's condition or disease in accordance with CMS Guidelines, the HC RFPs, and applicable legal settlements.

For children under the age of 21, requests for service will not be denied for lack of medical necessity unless a physician or other health care professional with appropriate clinical experience or expertise in treating the member's condition or disease determines:

- that the prescriber did not make a good faith effort to submit a complete request, or
- that the service or item is not medically necessary, after making a reasonable effort to consult with the prescriber. The reasonable effort to consult must be documented in writing.

3. Administrative Requirements

a. The BH-MCO's written policies and procedure must demonstrate how the MCO will ensure adequate care management and overall continuity of care among all levels and specialty areas.

b. The BH-MCO's written policies and procedures must explain how prior authorization data will be incorporated into the BH-MCO's overall Quality Management Plan.

4. Notification, Grievance, and Appeal Requirements

The MCO must demonstrate how written policies and procedures for requests for prior authorization comply and are integrated with the member notification requirements and member grievance and appeal requirements of the HC RFPs.

5. Requirements for Care Management/Care Coordination of Non Prior Authorized Service(s)/Items(s)

For purposes of tracking/care management/identification of certain diagnoses or conditions, and with advance written approval from the Department, the BH-MCO may choose to establish a process or protocol requiring notification prior to service delivery. If this process does not involve any approvals/denials or delays in receiving the service, the BH-MCO must notify providers of this notification requirement. This process may not be administratively cumbersome to providers and members. These situations need not comply with the other prior authorization requirements contained in this Appendix.

C. Prior Authorization Review and Decision Process:

1. Timeframes for Notice of Decisions

- a. The Contractor is required to process each request for Prior Authorization (prospective utilization review) of a service and ensure that the member is notified of the decision as expeditiously as the member's health condition requires, at least verbally within two (2) business days of receiving the request, unless additional information is needed. If no additional information is needed, the BH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two business days after the decision is made.
- b. If additional information is needed to make the decision, the BH-MCO must request the additional information from the provider within 48 hours of receipt of the request and allow up to 14 days for the provider to submit the additional information.
- c. The BH-MCO must provide written notice to the member that additional information has been requested; on the date the additional information was requested, using the template supplied by the Department as **Attachment 1**.
- d. If the requested information is provided within 14 days, the BH-MCO must make the determination to approve or deny the service and notify the member orally, within 2 business days of receipt of the additional information. The BH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two business days after the decision is made. If the additional information is not received within 14 days, the decision to approve or deny the service must be made based upon the available information and the member notified orally within 2 business days after the additional information was to have been received. The BH-MCO must mail written notice of the decision to the Member, the Member's PCP, and the prescribing Provider within two business days after the decision is made.
- e. In all cases, if the member does not receive written notification of the decision to approve or deny a covered service within twenty-one (21) days from the date the BH-MCO received the request, the service is automatically approved. To satisfy the twenty-one (21) day time period, the Contractor may mail written notice to the Member, the Member's PCP, and the prescribing Provider on or before the eighteenth (18th) day from the date the request is received. If the notice is not mailed by the eighteenth (18th) day after the request is received, then the BH-MCO

must hand deliver the notice to the Member, or the request is automatically authorized (i.e., deemed approved).

- f. If the member is currently receiving a requested service, the written notice of denial must be mailed to the member at least ten (10) days prior to the effective date of the denial of authorization for continued services. If probable recipient fraud has been verified, the period of advance notice is shortened to five (5) days. For inpatient services, the effective date on a denial of a continuation of services must be at least one day after the date of the notice. If the member wishes to have services continued as previously approved, the member must file a grievance or request a DPW Fair Hearing before the effective date of the denial as indicated on the denial notice.
- g. Advance notice is not required when the agency has factual information confirming the death of a recipient; the agency receives a clear written statement signed by a recipient that s/he no longer wishes to receive services or gives information that requires termination or reduction of services and indicates that s/he understands that termination or reduction must be the result of supplying that information; the recipient has been admitted to an institution where s/he is ineligible under the Contract for further services; the recipient's whereabouts are unknown and the post office returns agency mail directed to the recipient indicating no forwarding address; the recipient has been accepted for Medicaid services by another State; or a change in the level of medical care is prescribed by the recipient's physician.

2. Denial of Service:

A determination made by a BH-MCO in response to a provider's or member's request for approval to provide a service of a specific amount, duration and scope which:

- a. disapproves the request completely, or
- b. approves provision of the requested service(s), but for a lesser amount, scope or duration than requested or
- c. disapproves provision of the requested service(s), but approves provision of an alternative service(s), or
- d. reduces, suspends, or terminates a previously authorized service.

NOTE: A denial of a request for service must be based upon one of the following four reasons, along with an explanation for the reason, which must be explicitly stated on the notice of action:

- 1. The service requested is not a covered service.
- 2. The service requested is a covered service but not for this particular recipient (due to age, etc.)

3. The information provided is insufficient to determine that the service is medically necessary.
4. The service requested is not medically necessary.

3. Authorization Decisions:

A behavioral health denial decision based on medical necessity may be made only by a licensed physician or by a licensed psychologist if the requested service is within the psychologist's scope of practice. A licensed psychologist may not determine the medical necessity of requested inpatient services or prescribed medication. For substance abuse services, a decision based on medical necessity must be made by a licensed physician. Any representative of the BH-MCO who determines the medical necessity of a requested service must, in addition to being appropriately licensed, be appropriately experienced to render such a decision.

4. Denial Notice:

A written denial notice must be issued to the member using the notice template provided by the Department as **Attachment 2** of this Appendix when a service is denied as defined in Section C.2. of this Appendix.

**APPENDIX AA
ATTACHMENT 1
Notice of Request for Additional Information**

[Date additional information was requested from Provider]

Member Name
Address
City, State Zip

Member ID: *****

Subject: Request for Additional Information from your Provider

Dear **[Member Name]**:

[MCO Name] received a request for **[describe specific services]** from **[provider name]** on **[date received]**.

In order to decide if this service is medically necessary for you, **[MCO Name]** has requested the following additional information from your provider by **[date]**:

[list specific information requested]

[MCO Name] will make a decision on the requested services within 2 business days after receiving the additional information from your provider. **[MCO Name]** will notify you in writing within 2 business days after making its decision.

If we do not receive the additional information within 14 days, the decision to approve or deny the service will be made, based on the available information. **[MCO Name]** will notify you in writing within 2 business days after we should have received the additional information.

If you have any questions, please contact Member Services at **[phone #]**.

Sincerely,

[MCO Name]

cc: Prescribing Provider

[MCO: The following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information in this notice is available in other languages and formats by calling [Plan's Member Service's phone #].

**APPENDIX AA
ATTACHMENT 2a**

STANDARD DENIAL NOTICE

[DATE] *[This MUST be the date the notice is mailed]*

RE: *[Member's name and DOB]*

Dear *[Member Name]*:

[MCO Name] has reviewed the request for *[identify SPECIFIC service]* submitted by *[prescriber's name]* on behalf of *[patient name]* on *[date]*. After physician review, the request for service is:

Denied completely because: *[explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision]*.

This decision will take effect on *[date]*.

To continue getting services

If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address

2) File a Complaint or Grievance

You may file a complaint or grievance with *[MCO Name]* **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than [#] days *[MCO: Insert 30 unless plan will be using a shorter timeframe]* from when we receive it.

To file a complaint or grievance:

- Call [*MCO Name*] at [*phone #*]; or
- Send your complaint or grievance to [*MCO Name*] at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [*MCO Name*] at [*phone #*]
- Your doctor or psychologist must fax a letter to [*MCO fax #*] explaining why taking [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to decide your complaint or grievance could harm your health.

[*MCO Name*] will notify you of the decision within 48 hours from when we receive your doctor's or psychologist's letter, or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building # 32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827;
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a fair hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

Address for records information

4) Get a second opinion

You may get a second opinion from a provider in the [*MCO Name*] network. Call your PCP or [*MCO Name*] at [*phone #*] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.

If you have any questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [*MCO phone #*], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract.]

The information in this notice is available in other languages and formats by calling [*MCO Name*] at [*phone #*].

**APPENDIX AA
ATTACHMENT 2b**

STANDARD DENIAL NOTICE

[DATE] *[This MUST be the date the notice is mailed]*

RE: *[Member's name and DOB]*

Dear *[Member Name]*:

[MCO Name] has reviewed the request for *[identify SPECIFIC service]* submitted by *[prescriber's name]* on behalf of *[patient name]* on *[date]*. After physician review, the request for service is:

Approved other than as requested as follows: **[Describe the level, frequency, and duration of service approved and the level, frequency, and duration of service denied].**

The service is not approved as requested because: *[explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision]*

This decision will take effect on *[date]*.

To continue getting services

If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address

2) File a Complaint or Grievance

You may file a complaint or grievance with [*MCO Name*] **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] from when we receive it.

To file a complaint or grievance:

- Call [*MCO Name*] at [*phone #*]; or
- Send your complaint or grievance to [*MCO Name*] at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [*MCO Name*] at [*phone #*]
- Your doctor or psychologist must fax a letter to [*MCO fax #*] explaining why taking [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to decide your complaint or grievance could harm your health.

[*MCO Name*] will notify you of the decision within 48 hours from when we receive your doctor's or psychologist's letter, or within 3 business days from when we receive your request, whichever is sooner.

3) Request a Fair Hearing

You may ask for a fair hearing from the Department of Public Welfare. Your request for a fair hearing must be in writing and must be postmarked **within 30 days from the date on this notice**. Your request should include the following information:

- Your (the member's) name, social security number, and date of birth;
- A telephone number where you can be reached during the day;
- Whether you want to have a hearing in person or by telephone;
- A copy of this notice.

Your request for a fair hearing must be sent to the following address:

Department of Public Welfare
Office of Mental Health and Substance Abuse Services
Division of Grievances and Appeals
Beechmont Building # 32
P.O. Box 2675
Harrisburg, PA 17105-2675

The Department will issue a decision between 60 and 90 days from when it receives your request (see your member handbook for more details).

To ask for an early decision

If your doctor or psychologist believes that the usual time frame for deciding your request for a fair hearing could harm your health, you may ask that the fair hearing take place more quickly. To do this:

- Call the Department at 1-877-356-5355, or fax your request to 1-717-772-7827
- Your doctor or psychologist must fax a letter to [1-717-772-7827] explaining why taking the usual amount of time to decide your request for a fair hearing could harm your health. If your doctor or psychologist does not send a letter, your doctor or psychologist must testify at the fair hearing to explain why taking the usual amount of time to decide your request for a fair hearing could harm your health.

The Department will schedule a telephone hearing and notify you of its decision within three business days from when it receives your request.

You have the right to be present either in person or by telephone at the complaint review, grievance review, or fair hearing and to bring a family member, friend, lawyer or other person to help you.

If you file a complaint, grievance, or request for a fair hearing, you may request all documents relevant to this decision by sending a written request for the information to the following address:

Address for records information

4) Get a second opinion

You may get a second opinion from a provider in the [MCO Name] network. Call your PCP or [MCO Name] at [phone #] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service or item that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [MCO Phone #], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract:]

The information contained in this notice is available in other languages and formats by calling [MCO Name] at [phone #].

**APPENDIX AA
ATTACHMENT 2c**

STANDARD DENIAL NOTICE

[DATE] *[This MUST be the date the notice is mailed]*

RE: *[Member's name and DOB]*

Dear *[Member Name]*:

[MCO Name] has reviewed the request for *[identify SPECIFIC service]* submitted by *[prescriber's name]* on behalf of *[patient name]* on *[date]*. After physician review, the request for service is:

Denied as requested, but the following service is approved: *[describe the specific service approved, including the level, frequency, and duration of service]*.

A different service is approved because: *[explain in detail every reason for denial in addition to explanation for decision, include specific references to approved criteria, rules or protocols on which decision is based; if denied because of insufficient information, identify all additional information needed to render decision]*.

This decision will take effect on *[date]*.

To continue getting services

If you have been receiving the service that is being reduced, changed, or denied and you file a complaint, grievance, or request for a fair hearing (see instructions below) that is postmarked or hand-delivered **within 10 days of the date on this notice**, the service will continue until a decision is made.

IF YOU DO NOT AGREE WITH THIS DECISION, YOU MAY DO ONE OR ALL OF THE FOLLOWING:

1) Request Criteria

You may request a copy of the medical necessity criteria or other rules on which the decision was based by sending a written request to:

MCO address

2) File a Complaint or Grievance

You may file a complaint or grievance with [*MCO Name*] **within 45 days from the date you get this notice**. Your complaint or grievance will be decided no later than [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] from when we receive it.

To file a complaint or grievance:

- Call [*MCO Name*] at [*phone #*]; or
- Send your complaint or grievance to [*MCO Name*] at the following address:

MCO address for filing complaint or grievance

To ask for an early decision

If your doctor or psychologist believes that waiting [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to get a decision could harm your health, you may ask that your complaint or grievance be decided more quickly. To do this:

- Call [*MCO Name*] at [*phone #*];
- Your doctor or psychologist must fax a letter to [*MCO fax #*] explaining why taking [#] days [*MCO: Insert 30 unless plan will be using a shorter timeframe*] to decide your complaint or grievance could harm your health.

[*MCO Name*] will notify you of the decision within 48 hours from when we receive your doctor's or psychologist's letter, or within 3 business days from when we receive your request, whichever is sooner.

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- Your (the member's) name, social security number and date of birth;
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Address for records information

4) Get a second opinion

You may get a second opinion from a provider in the [*MCO Name*] network. Call your PCP or [*MCO Name*] at [*phone #*] to get a referral for a second opinion. Asking for a second opinion will not extend the time for filing a complaint, grievance, or request for a fair hearing, and it will not continue any service that you have been receiving.

If you have questions or need help filing a complaint, grievance or request for a fair hearing, you may call us at [*MCO Phone #*], the legal aid office at 1-800-322-7572 (www.palegalservices.org), or the Pennsylvania Health Law project at 1-800-274-3258 (www.phlp.org).

cc: Prescribing Provider

[MCO, the following statement must appear in English, Russian, Cambodian, Vietnamese, Spanish, Chinese, and any other language as required by the contract.]

FINAL 12/11/03

The information contained in this notice is available in other languages and formats by calling [*MCO Name*] at [*phone #*].