



State of Vermont  
 Department of Vermont Health Access  
 312 Hurricane Lane, Suite 201  
 Williston, VT 05495-2087

Agency of Human Services

**NOTICE OF DECISION - Prior Authorization Approval**  
**Department of Vermont Health Access**

Date: [REDACTED]

**Test Template**  
**1234 Template Test Dr**  
**Apt 11**  
**Test City, IL 60510 1234**

**This letter is important. If you do not understand it, take it to your local office for help.**

Cette lettre est importante. Si vous ne la comprenez pas, apportez-la à votre bureau local pour recevoir de l'aide.

Esta carta es importante. Si no la entiende, llévela a su oficina local para solicitar ayuda.

Это важное письмо. Если вам оно непонятно, возьмите его и обратитесь за помощью в местное отделение.

Ovaj dopis je važan. Ukoliko je nerazumljiv za vas onda ga ponesite i obratite se lokalnoj kancelariji za pomoć.

Lưu trữ này rất quan trọng. Nếu quý vò không hiểu nói dung trong nóu, hãy đem nó này đến văn phòng tại địa phương của quý vò để được giúp đỡ.

**Dear Test Template,**

Catamaran™, working with the Department of Vermont Health Access (DVHA), has received your request from [REDACTED] MD that the State pay for [REDACTED] [REDACTED] in a quantity of [REDACTED] for a [REDACTED] day supply.

The request has been approved for the period [REDACTED] to [REDACTED].

Prior authorization is a condition of reimbursement; it is not a guarantee of payment. All other State and Federal requirements must and Federal still be met. This approval is valid only if you are eligible on the date of service. If you have other health insurance, this approval is valid only for the portion of the pharmacy claim that you are entitled to under your benefit with the State of Vermont.

If you have questions regarding this letter, please contact [REDACTED] MD.

**Prior Authorization Services**  
**Catamaran**

If you disagree with this decision, your provider may request a reconsideration. You may request an internal appeal and/or a fair hearing before the Human Services Board. Please refer to page 2 for additional information.



Your provider may ask for a reconsideration of the decision on page 1. This is an informal way to ask the person who made this decision to rethink it. More information can be submitted that would clarify or add to what had already been sent in.

An internal appeal and/or a fair hearing must be requested within 90 days of the date of the decision on page 1. If you disagree with the appeal decision, you have 90 days from the date of this decision or 30 days from the appeal decision date to file a fair hearing, if you have not already done so. If you mail a letter appealing this decision, requesting a fair hearing or both, the request date is the postmark date.

An internal appeal is another review by a qualified person who wasn't involved with this decision. A fair hearing is a legal proceeding in which an impartial hearing officer will review the decision.

If the decision on page 1 is to reduce or end services you are currently getting and you want continued benefits during your appeal or fair hearing, you must ask us before the effective date of the decision. If you get services during your appeal and/or fair hearing, you may be asked to pay for them if the appeal and/or fair hearing is not decided in your favor.

You have the right to take part in the meeting(s) where the decision about your appeal and/or fair hearing is (are) being made. You will get more information about the meeting(s) after you have asked for an appeal and/or fair hearing. Appeals will be decided within 45 days of when we receive your appeal. This may be extended up to 14 more days if it is to your benefit. You may ask for the extension. The decision will be made within 59 days.

Emergency (expedited) appeals may be requested in situations when you or your doctor believe(s) that the time for a regular appeal could seriously risk your life or health. Requests for emergency (expedited) appeals may be made by calling Health Access Member Services at 1-800-250-8427.

***Please call Health Access Member Services at 1-800-250-8427 for more information or to file an appeal and/or fair hearing.***

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If you are in traditional Medicaid or Dr. Dynasaur, and this is a denial for an item or service that is not covered, you may ask for an exception (DVHA Forms 211RCMN, 211RC, and 211RCE). Call Health Access Member Services at 1-800-250-8427 for more information or to request forms. These forms can also be found on DVHA's web site at: <http://dvha.vermont.gov/for-consumers>.

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For legal assistance or help solving a problem, call your local Vermont Legal Aid Office or the Office of Health Care Ombudsman at 1-800-917-7787. Their services are free.



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