

**Member Services**

Mail Route CP540  
PO Box 9310  
Minneapolis, MN 55440-9310



July 11, 2023

**Important Medica Information**

Member Name  
Address Line 1  
Address Line 2  
City, ST Zip+4

**Your Recent Appeal Request**

RE: Member Name  
ID: - -00

Hello First Name,

Thank you for calling us on Month Day Year. At that time, you asked to file a written appeal. Your appeal request is important to us and we would like to learn more.

Please complete the appeal form and return it to us in the enclosed reply envelope. Once we receive your written appeal, we will carefully review it and respond to you in writing in no more than 30 days.

**Questions? We're here to help**

Call Member Services at 952-992-2580 or 1-888-347-3630 between the hours of 8 a.m. and 9 p.m. Central, seven days a week, October 1 – March 31. From April 1 – September 30, call us 8 a.m. to 9 p.m., Central, Monday through Friday to speak with a representative. TTY: 711.

Thank you,

Regulatory Appeal Advisor  
Enclosures: Reply Envelope  
Appeal Form

Medica Member Service 1 (888) 347-3630 (TTY: 711)  
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An Equal Opportunity Employer

Medica DUAL Solution® and Medica AccessAbility Solution® Enhanced are HMO D-SNPs that contract with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in Medica DUAL Solution and Medica AccessAbility Solution Enhanced depends on contract renewal.



## APPEAL FORM

**Medica DUAL Solution® (HMO D-SNP)**

**Medica AccessAbility Solution® Enhanced (HMO D-SNP)**

Medica ID Number: \_\_\_\_\_

Member Name: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Dear Member:

This form is one of the ways that you can file an appeal through Medica. You can fill out this form and mail it to Medica at PO Box 9310, CP540 Minneapolis, MN 55440-9310. Include your name, Medica ID number, phone number and the reason for your appeal. Please sign and date the form. Once the form is received, we will send you an acknowledgement letter within 10 days.

If you choose to file an oral appeal, please call Medica Member Services and give the information to the representative over the phone. A Regulatory and Appeals Advisor will contact you within 24 business hours. If the call is received on Friday afternoon, you may not receive a call back until the following Monday.

The section below is to help you file the appeal you expressed when you called Medica Member Services. Please explain your reasons for appealing and return this signed form promptly. Attach more pages as necessary.

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This form should be mailed to:

**Medica Member Services**  
**PO Box 9310, CP540**  
**Minneapolis, MN 55440-9310**

The Ombudsperson for Public Managed Health Care Programs may be able to give you more information about the appeal process with the health plan or the State. Their phone number is 651-431-2660 or 1-800-657-3729 (toll-free). Or use your preferred relay service.

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**Member Signature**

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**Date**

**Medica Member Services**

1 (888) 347-3630 (toll free) TTY: 711

Attention. If you need free help interpreting this document, call the above number.

ያስተውሉ፡ ካለምንም ክፍያ ይህንን ዶክመንት የሚተረጎምሎ አስተርጓሚ ከፈለጉ ከላይ ወደተጻፈው የስልክ ቁጥር ይደውሉ።

ملاحظة: إذا أردت مساعدة مجانية لترجمة هذه الوثيقة، اتصل على الرقم أعلاه.

သတိ။ ဤတွဲရက်စာတမ်းအားအခမဲ့ဘာသာပြန်ပေးခြင်း အကူအညီလိုအပ်ပါက၊ အထက်ပါဖုန်းနံပါတ်ကိုခေါ်ဆိုပါ။

កំណត់សំគាល់ ។ បើអ្នកត្រូវការជំនួយក្នុងការបកប្រែឯកសារនេះដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទតាមលេខខាងលើ ។

請注意，如果您需要免費協助傳譯這份文件，請撥打上面的電話號碼。

Attention. Si vous avez besoin d'une aide gratuite pour interpréter le présent document, veuillez appeler au numéro ci-dessus.

Thov ua twb zoo nyeem. Yog hais tias koj xav tau kev pab txhais lus rau tsab ntaub ntauv no pub dawb, ces hu rau tus najnpawb xov tooj saum toj no.

ဟ်သုဉ်ဟ်သးဘဉ်တက့ၢ်. ဝဲနမ့ၢ်လိဉ်ဘဉ်တၢ်မၤစၢၤကလိလၢတၢ်ကကျိးထံဝဲဒၣ်လံာ် တီလံာ်မိတခါအံၤန့ၣ်,ကိးဘဉ်လီတဲစိနီၢ်ဂံၢ်လၢထးအံၤန့ၣ်တက့ၢ်.

알려드립니다. 이 문서에 대한 이해를 돕기 위해 무료로 제공되는 도움을 받으시려면 위의 전화번호로 연락하십시오.

ໂປຣດຊາບ. ຖ້າຫາກ ທ່ານຕ້ອງການການຊ່ວຍເຫຼືອໃນການແປເອກະສານນີ້ພຣີ, ຈົ່ງໂທໄປທີ່ໝາຍເລກຂ້າງເທິງນີ້.

Hubachiisa. Dokumentiin kun tola akka siif hiikamu gargaarsa hoo feete, lakkoobsa gubbatti kenname bilbili.

Внимание: если вам нужна бесплатная помощь в устном переводе данного документа, позвоните по указанному выше телефону.

Digniin. Haddii aad u baahantahay caawimaad lacag-la'aan ah ee tarjumaadda (afcelinta) qoraalkan, lambarka kore wac.

Atención. Si desea recibir asistencia gratuita para interpretar este documento, llame al número indicado arriba.

Chú ý. Nếu quý vị cần được giúp đỡ dịch tài liệu này miễn phí, xin gọi số bên trên.

LB2 (10-20)

## Civil Rights Notice

**Discrimination is against the law. Medica** does not discriminate on the basis of any of the following:

- race
- color
- national origin
- creed
- religion
- sexual orientation
- public assistance status
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)
- marital status
- political beliefs
- medical condition
- health status
- receipt of health care services
- claims experience
- medical history
- genetic information

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Medica. You can file a complaint and ask for help filing a complaint in person or by mail, phone, fax, or email at:

Medica Civil Rights Coordinator  
 P.O. Box 9310, Mail Route CP250  
 Minneapolis, MN 55443-9310  
 Toll Free: 1 (888) 347-3630  
 TTY: 711  
 Fax: 952-992-3422  
 Email: [civilrightscordinator@medica.com](mailto:civilrightscordinator@medica.com)

**Auxiliary Aids and Services:** Medica provides auxiliary aids and services, like qualified interpreters or information in accessible formats, free of charge and in a timely manner to ensure an equal opportunity to participate in our health care programs. **Contact** Medica at 1 (888) 347-3630 (toll free), TTY: 711 or at [medica.com/contactmedicaid](http://medica.com/contactmedicaid).

**Language Assistance Services:** Medica provides translated documents and spoken language interpreting, free of charge and in a timely manner, when language assistance services are necessary to ensure limited English speakers have meaningful access to our information and services. **Contact** Medica at 1 (888) 347-3630 (toll free), TTY: 711 or at [medica.com/contactmedicaid](http://medica.com/contactmedicaid).

### Civil Rights Complaints

You have the right to file a discrimination complaint if you believe you were treated in a discriminatory way by Medica. You may also contact any of the following agencies directly to file a discrimination complaint.

#### U.S. Department of Health and Human Services Office for Civil Rights (OCR)

You have the right to file a complaint with the OCR, a federal agency, if you believe you have been discriminated against because of any of the following:

- race
- color
- national origin
- age
- disability
- sex
- religion (in some cases)

Contact the OCR directly to file a complaint:

Office for Civil Rights  
U.S. Department of Health and Human Services  
Midwest Region  
233 N. Michigan Avenue, Suite 240  
Chicago, IL 60601  
Customer Response Center: Toll-free: 800-368-1019  
TDD Toll-free: 800-537-7697  
Email: [ocrmail@hhs.gov](mailto:ocrmail@hhs.gov)

### **Minnesota Department of Human Rights (MDHR)**

In Minnesota, you have the right to file a complaint with the MDHR if you have been discriminated against because of any of the following:

- race
- color
- national origin
- religion
- creed
- sex
- sexual orientation
- marital status
- public assistance status
- disability

Contact the **MDHR** directly to file a complaint:

Minnesota Department of Human Rights  
540 Fairview Avenue North, Suite 201  
St. Paul, MN 55104  
651-539-1100 (voice)  
800-657-3704 (toll-free)  
711 or 800-627-3529 (MN Relay)  
651-296-9042 (fax)  
[Info.MDHR@state.mn.us](mailto:Info.MDHR@state.mn.us) (email)

### **Minnesota Department of Human Services (DHS)**

You have the right to file a complaint with DHS if you believe you have been discriminated against in our health care programs because of any of the following:

- race
- color
- national origin
- religion (in some cases)
- age
- disability (including physical or mental impairment)
- sex (including sex stereotypes and gender identity)

Complaints must be in writing and filed within 180 days of the date you discovered the alleged discrimination. The complaint must contain your name and address and describe the discrimination you are complaining about. We will review it and notify you in writing about whether we have authority to investigate. If we do, we will investigate the complaint.

DHS will notify you in writing of the investigation's outcome. You have the right to appeal if you disagree with the decision. To appeal, you must send a written request to have DHS review the investigation outcome. Be brief and state why you disagree with the decision. Include additional information you think is important.

If you file a complaint in this way, the people who work for the agency named in the complaint cannot retaliate against you. This means they cannot punish you in any way for filing a complaint. Filing a complaint in this way does not stop you from seeking out other legal or administrative actions.

Contact **DHS** directly to file a discrimination complaint:

Civil Rights Coordinator  
Minnesota Department of Human Services  
Equal Opportunity and Access Division  
P.O. Box 64997  
St. Paul, MN 55164-0997  
651-431-3040 (voice) or use your preferred relay service

American Indians can continue or begin to use tribal and Indian Health Services (IHS) clinics. We will not require prior approval or impose any conditions for you to get services at these clinics. For elders age 65 years and older this includes Elderly Waiver (EW) services accessed through the tribe. If a doctor or other provider in a tribal or IHS clinic refers you to a provider in our network, we will not require you to see your primary care provider prior to the referral.