

Letter #6

(CRS Regional Contractor Letterhead)

**Notice of Decision by CRS
on
AHCCCS Health Plan /Program Contractor Request for Review**

I. Date

II.

III.

IV. To: Health Plan Name

V. Address

Re: *(Member name, CRS Member # and AHCCCS ID#)*

Dear: *(Plan Medical Director)*

We received your Request for Review dated _____ asking us to review our decision

to _____.

After reviewing our original decision, we have decided *(that the first decision was right/ or/ to change our decision to _____.)* We have made this decision based on *(Please include the legal citations or authorities supporting the determination.)*

If you do not agree with our decision you may file a request for a hearing with the AHCCCS Administration within 30 days of receipt of this letter.

If you have questions, please call us at *(XXX) XXX-XXXX*.

Sincerely,

CRS Regional Medical Director