Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed toward the end under “Get help & more information.” You can also see Chapter 9 of the Member Handbook for information about how to make an appeal.

Notice of Denial of Medical Coverage

Date: 

Member number: 

Name: 

<Insert other identifying information, as necessary (e.g., provider name, enrollee’s Medicaid number, service subject to notice, date of service).>

Your request was denied

We’ve <denied, stopped, reduced, suspended> the medical services/items listed below requested by you or your provider:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

Why did we deny your request?

We <denied, stopped, reduced, suspended> the medical services/items listed above because <Provide specific rationale for decision and include State or Federal law and/or Evidence of Coverage (Member Handbook) provisions to support decision>:

______________________________________________________________________________________

______________________________________________________________________________________

______________________________________________________________________________________

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision

You have the right to ask IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) to review our decision by asking us for a Level 1 Appeal (sometimes called an “internal appeal” or “plan appeal”). In special
cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan. You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

Ask IEHP DualChoice for a Level 1 Appeal within 60 calendar days of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled “How to ask for a Level 1 Appeal with IEHP DualChoice” for information on how to ask for a plan level appeal.

**How to keep your services while we review your case:** If we’re stopping or reducing a service, you can keep getting the service while your case is being reviewed. **If you want the service to continue, you must ask for an appeal within 10 calendar days of the date of this notice or before the service is stopped or reduced, whichever is later.**

If you want someone else to act for you

You can name a relative, friend, attorney, doctor, or someone else to act as your representative. If you want someone else to act for you, call us at: 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays to learn how to name your representative. TTY users call 1-800-718-4347. Both you and the person you want to act for you must sign and date a statement saying this is what you want. You’ll need to mail or fax this statement to us. Keep a copy for your records.

There are 2 kinds of Level 1 appeals with IEHP DualChoice

**Standard Appeal** – We’ll give you a written decision on a standard appeal within 30 calendar days after we get your appeal. Our decision might take longer if you ask for an extension, or if we need more information about your case. We’ll tell you if we’re taking extra time and will explain why more time is needed. If your appeal is for payment of a medical services/items you’ve already received, we’ll give you a written decision within 60 calendar days.

**Fast (Expedited) Appeal** – We’ll give you a decision on a fast appeal as quickly as your condition requires, and always within 72 hours after we get your appeal. You can ask for a fast appeal if you or your doctor believe your health could be seriously harmed by waiting for a decision on a standard appeal.

We’ll automatically give you a fast appeal if a doctor asks for one for you or if your doctor supports your request. If you ask for a fast appeal without support from a doctor, we’ll decide if your request requires a fast appeal. If we don’t give you a fast appeal, we’ll give you a decision within 30 calendar days.

How to ask for a Level 1 Appeal with IEHP DualChoice

**Step 1:** You, your representative, or your provider must ask for an appeal within 60 calendar days of getting this notice.

Your request must include:

- Your name
- Address
- Member number
- Reasons for appealing
- Whether you want a standard or fast appeal (for a fast appeal, explain why you need one).
• Any evidence you want us to review, such as medical records, doctors’ letters (such as a doctor’s supporting statement if you request a fast appeal), or other information that explains why you need the medical services/items. Call your doctor if you need this information.

We recommend keeping a copy of everything you send us for your records.

You can ask to see the medical records and other documents we used to make our decision before or during the appeal. At no cost to you, you can also ask for a copy of the guidelines we used to make our decision.

**Step 2:** Mail, fax, or deliver your appeal or call us.

**For a Standard Appeal:**

Mailing Address: IEHP DualChoice  
P.O. Box 1800  
Rancho Cucamonga, CA 91729-1800  
Phone: 1-877-273-IEHP (4347)  
TTY Users Call: 1-800-718-4347  
Fax: 909-890-5748

If you ask for a standard appeal by phone, we will repeat your request back to you to be sure we have documented it correctly. We will also send you a letter confirming what you told us. The letter will tell you how to make any corrections.

**For a Fast Appeal:**

Phone: 1-877-273-IEHP (4347)  
TTY Users Call: 1-800-718-4347  
Fax: 909-890-5748

**What happens next?**

If you ask for a Level 1 Appeal and we continue to deny your request for a service, we’ll send you a written decision.

If the service was originally a Medicare service or a service covered by both Medicare and Medi-Cal, we will automatically send your case to an independent reviewer. If the independent reviewer denies your request, the written decision will explain if you have additional appeal rights.

If the service was a Medi-Cal service, you can ask for an **Independent Medical Review (IMR)** or a **State Hearing**. Your written decision will give you instructions on how to request the next level of appeal. Information is also below.

**How to ask for an Independent Medical Review (IMR)**

You can ask for an Independent Medical Review (IMR) for Medi-Cal covered services and items from the California Department of Managed Health Care (Department). You can ask for an IMR if you disagree with IEHP DualChoice’s Level 1 Appeal decision or if IEHP DualChoice has not resolved your Level 1 Appeal after 30 days. In special cases, you can also ask for an Independent Medical Review (IMR) without first appealing to our plan.

In most cases, you must file a Level 1 Appeal with IEHP DualChoice before requesting an IMR; however, you may be able to have an IMR without appealing to IEHP DualChoice first if:

• Your problem is urgent and involves an immediate and serious threat to your health.
• IEHP DualChoice denied a Medi-Cal service or treatment because it is experimental or investigational.

You cannot ask for an IMR if you have already had a State Hearing on the same issue. If you get an IMR and you are not satisfied with the result, you can still ask for a State Hearing.

**How to ask for an IMR.** Fill out the online Independent Medical Review/Complaint Form available at [https://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx](https://www.dmhc.ca.gov/fileacomplaint/submitanindependentmedicalreviewcomplaintform.aspx) or you can fill out the hard copy IMR application form that is included with this notice and send it to:

Help Center  
Department of Managed Health Care  
980 Ninth Street, Suite 500  
Sacramento, CA 95814-2725  
FAX: 916-255-5241

If you choose to do so, you may attach copies of letters or other documents about the service or item that was denied. If you do, send copies of documents, not originals. The Department Help Center may not be able to return all original documents.

You or your representative must ask for an IMR within **6 months** after we send you a written decision. However, the Department may extend the 6-month deadline for good reasons such as you had a medical condition that prevented you from asking for the IMR within 6 months or you did not get adequate notice of the IMR process.

Call the **California Department of Managed Health Care (DMHC) toll-free at 1-888-466-2219** for free help. The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-877-273-IEHP (4347)** and use your health plan’s grievance process before contacting the Department. Using this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number (**1-888-466-2219**) and a TTY line (**1-877-688-9891**) for the hearing and speech impaired. The Department’s Internet Web site [www.dmhc.ca.gov](http://www.dmhc.ca.gov) has complaint forms, IMR application forms, and instructions online.

**What happens next?**

If you qualify for an IMR, the DMHC will review your case and send you a letter within **7 calendar days** telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within **30 calendar days**. You should receive the IMR decision within **45 calendar days** of the submission of the completed application.

If your case is urgent and you qualify for an IMR, the DMHC will review your case and send you a letter within **2 calendar days** telling you that you qualify for an IMR. After your application and supporting documents are received from your plan, the IMR decision will be made within **3 calendar days**. You should receive the IMR decision within **7 calendar days** of the submission of the completed application.
Doctors who are not part of IEHP DualChoice will review your case. The DMHC will send you a letter explaining the decision. If the IMR decision is in your favor, IEHP DualChoice must give you the service or treatment you asked for. If you do not agree with the decision, you can ask for a State Hearing as long as you have not had a State Hearing on the same issue.

If you do not qualify for an IMR, your issue will be reviewed through DMHC’s standard complaint process. You will receive a written notice of the decision within 30 days. If you decide not to use the IMR process, you may be giving up your rights under California law to pursue legal action against IEHP DualChoice about the service or treatment you are asking for.

How to ask for a State Hearing

If the service was a Medi-Cal covered service or item, you can ask for a State Hearing. You can only ask for a State Hearing after you have appealed to our health plan and received a written decision with which you disagree. Please note that if you have a State Hearing, you will not be able to ask for an Independent Medical Review (IMR).

Step 1: You or your representative must ask for a State Hearing within 120 days of the date of our notice to you that the adverse benefit determination (Level 1 appeal decision) has been upheld. Fill out the “Form to File a State Hearing” that will be provided with your appeal decision notice. Make sure you include all of the requested information.

Step 2: Send your completed form to:

California Department of Social Services  
State Hearings Division  
P.O. Box 944243, Mail Station 9-17-37  
Sacramento, CA 94244-2430  
FAX: 916-651-5210 or 916-651-2789

You can also request a State Hearing by calling 1-800-952-5253 (TTY: 1-800-952-8349). If you decide to make a request by phone, you should be aware that the phone lines are very busy.

What happens next?

The State will hold a hearing. You may attend the hearing in person or by phone. You’ll be asked to tell the State why you disagree with our decision. You can ask a friend, relative, advocate, provider, or lawyer to help you. You’ll get a written decision that will explain if you have additional appeal rights.

A copy of this notice has been sent to: <insert name>.

Get help & more information

• Call IEHP DualChoice at 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. You can also visit our website at www.iehp.org.

• Call the California Department of Managed Health Care for free help in understanding your rights and information about the complaint and Independent Medical Review (IMR) process at 1-888-466-2219.

• Call the Health Consumer Alliance for free help with your health care at 1-888-804-3536.
• Call the **Cal MediConnect Ombuds Program** for free help. The Cal MediConnect Ombuds Program helps people enrolled in Cal MediConnect with service or billing problems. They can talk with you about how to make an appeal and what to expect during the appeal process. The phone number is 1-855-501-3077.

• Call **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

• Call the **Medicare Rights Center** at 1-888-HMO-9050.

• Call the **Health Insurance Counseling and Advocacy Program (HICAP)** for free help. HICAP is an independent organization. It is not connected with this plan. The phone number is 1-800-434-0222.

• Talk to **your doctor or other provider**. Your doctor or other provider can ask for a coverage decision or appeal on your behalf.

• You can also see **Chapter 9 of the Member Handbook** for information about how to make an appeal.

IEHP DualChoice Cal MediConnect Plan (Medicare-Medicaid Plan) is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees.

ATTENTION: If you speak Spanish, language assistance services, free of charge, are available to you. Call 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. The call is free.

ATENCIÓN: Si prefiere comunicarse en un idioma diferente al inglés, tiene a su disposición los servicios de un intérprete sin cargo para usted. Llame a Servicios para Miembros de IEHP DualChoice al 1-877-273-IEHP (4347), de 8am-8pm (Hora del Pacífico), los 7 días de la semana, incluidos los días festivos. Los usuarios TTY deben llamar al 1-800-718-4347. La llamada es gratuita.

You can get this document for free in other formats, such as large print, braille, or audio. Call 1-877-273-IEHP (4347), 8am-8pm (PST), 7 days a week, including holidays. TTY users call 1-800-718-4347. The call is free.
INDEPENDENT MEDICAL REVIEW (IMR) APPLICATION/COMPLAINT FORM

IMPORTANT INFORMATION
You can submit your IMR Application/Complaint Form online at: www.HealthHelp.ca.gov
✓ FREE: The IMR/Complaint process is free.
✓ FAST: IMRs are usually decided within 45 days, or within 7 days if the health issue is urgent.
✓ SUCCESSFUL: Approximately 60% of patients receive the requested service through IMR.
✓ FINAL: Health plans must follow the IMR decision and promptly provide the service.

PATIENT INFORMATION
First Name ___________________________ Middle Initial ___ Last Name ___________________________
Patient’s Date of Birth (mm/dd/yyyy) ____________ Gender: ☐ Male ☐ Female ☐ Other ____________
Name of Parent or Guardian if Filing for Minor Child ____________________________
Street Address ____________________________
City ____________________________ State _______ Zip ____________________________
Primary Phone # ____________________________ Secondary Phone # ____________________________
Email Address ____________________________
Would you like communication/correspondence sent to this email? ☐ Yes ☐ No
Health Plan Name ____________________________ Patient’s Membership # ____________________________
Medical Group Name (if enrolled in a medical group) ____________________________
Employer ____________________________

Do you want someone to help you with your complaint? ☐ Yes ☐ No
If yes, please complete the attached ‘Authorized Assistant Form.’

Do you have Medi-Cal? ☐ Yes ☐ No
If yes, have you filed a Request for a State Fair Hearing? ☐ Yes ☐ No

Do you have Medicare or Medicare Advantage? ☐ Yes ☐ No

Have you filed a complaint or grievance with your health plan? ☐ Yes ☐ No

Do you want payment for a health care service that you already received? ☐ Yes ☐ No
If yes, list the date(s) of service, and the provider’s name:

YOUR HEALTH PROBLEM
(Use a separate sheet and attach other documents, if needed.)

Do you want your health plan to pay for future services? ☐ Yes ☐ No
What is your medical condition or doctor’s diagnosis (Please be specific) __________________________________________

What medical treatment(s)/service(s) and/or medication(s) are you asking for? (Please be specific)

Did your health plan deny, delay or modify your treatment? ☐ Yes ☐ No

If yes, please check the reason given: (Check one)

☐ Not Medically Necessary  ☐ Experimental or Investigational  ☐ Not an Emergency/Urgent

☐ Not an Emergency/Urgent  ☐ Other (Please explain below)

List the name and phone number of your primary care doctor and other providers who have seen, treated, or advised you for this condition.

Have you seen any out-of-network providers for your condition? ☐ Yes ☐ No

If yes, please include the medical records with this form.

Briefly describe the problem you are having with your plan. For example, explain if the problem is a denied treatment, an unpaid bill, trouble getting an appointment or medication, or if your coverage has been cancelled by the health plan.

MEDICAL RELEASE

I request the Department of Managed Health Care (Department) to make a decision about my problem with my health plan. I request the Department to review my Independent Medical Review (IMR) Application/Complaint Form to determine if my complaint qualifies for an IMR or the Department’s Complaint process. I allow my providers, past and present, and my plan to release my medical records and information to review this issue. These records may include medical, mental health, substance abuse, HIV, diagnostic imaging reports, and other records related to my case. These records may also include non-medical records and any other information related to my case. I allow the Department to review these records and information and send them to my plan. My permission will end one year from the date below, except as allowed by law. For example, the law allows the Department to continue to use my information internally. I can end my permission sooner if I wish. All the information that I have provided on this sheet is true.

Patient or Parent Name (Print) __________________________________________

Patient or Parent Signature __________________________________________ Date __________

Please see the instruction sheet for mailing or faxing information.

STATISTICAL INFORMATION ONLY

You are asked to voluntarily provide the following information. Giving this information will help the Department identify any patterns of problems. Health and Safety Code section 1374.30 authorizes the Department to obtain this information for research and statistical purposes. Giving this information is optional and will not affect the IMR or complaint decision in any way.

Primary Language Spoken: ____________________________

Would you like us to communicate/correspond with you in your primary language? ☐ Yes

Race/Ethnicity: __________________________________________
AUTHORIZED ASSISTANT FORM

If you want to give another person permission to assist you with your Independent Medical Review (IMR) or complaint, complete Parts A and B below.

If you are a parent or legal guardian filing this IMR or complaint for a child under the age of 18, you do not need to complete this form.

If you are filing this IMR or complaint for a patient who cannot complete this form because the patient is either incompetent or incapacitated, and you have legal authority to act for this patient, please complete Part B only. Also attach a copy of the power of attorney for health care decisions or other documents that say you can make decisions for the patient.

PART A: COMPLETED BY PATIENT

I allow the person named below in Part B to assist me in my IMR or complaint filed with the Department of Managed Health Care (Department). I allow the Department and IMR staff to share information about my medical condition(s) and care with the person named below. This information may include mental health treatment, HIV treatment or testing, alcohol or drug treatment, or other health care information.

I understand that only information related to my IMR or complaint will be shared.

My approval of this assistance is voluntary and I have the right to end it. If I want to end it, I must do so in writing.

Patient Name (Print)__________________________________________________________

Patient Signature_________________________________________________________ Date________________

PART B: COMPLETED BY PERSON ASSISTING PATIENT

Name of Person Assisting (Print)__________________________________________________

Address__________________________________________________________

City________________________________________ State____ Zip________________

Relationship to Patient_______________________________________________________

Primary Phone #________________________ Secondary Phone #____________________

Email Address______________________________________________________________

☐ My power of attorney for health care decisions or other legal document is attached.
If you have questions, call the Help Center at 1-888-466-2219 or TDD at 1-877-688-9891. This call is free.

**Before You File:**

In most cases, you must complete your plan’s complaint or grievance process before you file a complaint or IMR request to the Department. Your plan must give you a decision within 30 days or within 3 days if your problem is an immediate and serious threat to your health.

If your plan denied your treatment because it was experimental/investigational, you do not have to take part in your plan’s complaint or grievance process before you file an IMR application.

You must apply for an IMR within six months after your health plan sends you a written response to your appeal. The Department may accept your application after six months if it is determined that circumstances prevented timely submission. Please be aware that if you decide not to file a complaint with the DEPARTMENT for an issue that would qualify for an IMR, you may be giving up your rights to pursue legal action against your plan regarding the service or treatment you are requesting.

**How to File:**

1. File online at [www.HealthHelp.ca.gov](http://www.HealthHelp.ca.gov). [This is the fastest way.]
   OR
   Fill out and sign the IMR Application/Complaint Form.
2. If you want someone to help you with your IMR or complaint, complete the ‘Authorized Assistant Form.’
3. If you have medical records from out of network providers, please include them with your IMR Application/Complaint Form. Your plan will provide medical records from network providers.
4. You may include other documents that support your request. However, there is no need to provide any documents or correspondence between you and your plan relating to this complaint. The Department will obtain this information directly from your plan as part of the investigation.
5. If you are not submitting online, please mail or fax your form and any supporting documents to:
   Department of Managed Health Care Help Center
   980 9th Street, Suite 500
   Sacramento, CA 95814-2725
   FAX: 916-255-5241

**What Happens Next?**

The Help Center will send you a letter within seven days telling you if you qualify for an IMR. If it is determined that your complaint qualifies for an IMR, your case is assigned to a state contractor who will perform the review. The state contractor is also known as the Independent Medical Review Organization (IMRO). All of the information in the Help Center’s possession related to your complaint, including your medical records, will be sent to the IMRO. The IMRO will make a decision usually within 30 days or within seven days if your case is urgent. You will be notified in writing of the decision.

If it is determined that your complaint should be reviewed through the Consumer Complaint process, a decision about your issue will be made within 30 days. You will be notified in writing of the decision.
The Information Practices Act of 1977 (California Civil Code Section 1798.17) requires the following notice.

- California’s Knox-Keene Act gives the Department the authority to regulate health plans and investigate the complaints of health plan members.
- The Department’s Help Center uses your personal information to investigate your problem with your plan and to provide an IMR if you qualify for one.
- You provide the Department this information voluntarily. You do not have to provide this information. However, if you do not, the Department may not be able to investigate your complaint or provide an IMR.
- The Department may share your personal information, as needed, with the plan and providers who conduct the IMR.
- The Department may also share your information with other government agencies as required or allowed by law.
- You have a right to see your personal information. To do this, contact the Department Records Request Coordinator, Department of Managed Health Care, Office of Legal Services, 980 9th Street Suite 500, Sacramento CA  95814-2725, or call 916-322-6727.
Inland Empire Health Plan (IEHP) complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. IEHP does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

IEHP:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact IEHP Member Services at 1-877-273-4347 (TTY: 1-800-718-4347).

If you believe that IEHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201
Inland Empire Health Plan (IEHP) cumple con las leyes Federales de derechos civiles aplicables y no discrimina por motivos de raza, color, nacionalidad, edad, discapacidad o sexo. IEHP no excluye a las personas ni las trata de forma diferente debido a su raza, color, nacionalidad, edad, discapacidad o sexo.

IEHP:

- Proporciona asistencia y servicios gratuitos a personas con discapacidad para que se comuniquen de manera eficaz con nosotros, como los siguientes:
  - Intérpretes de lenguaje de señas calificados
  - Información escrita en otros formatos (letra grande, audio, formatos electrónicos accesibles, otros formatos)

- Proporciona servicios lingüísticos gratuitos a personas que prefieren comunicarse en un idioma diferente al inglés, como los siguientes servicios:
  - Intérpretes calificados
  - Información escrita en otros idiomas


Si considera que IEHP no le proporcionó estos servicios o lo discriminó de otra manera por motivos de raza, color, nacionalidad, edad, discapacidad o sexo, puede presentar una queja formal ante el Coordinador de Derechos Civiles:

Inland Empire Health Plan, Attn: Civil Rights Coordinator,
10801 Sixth Street, Suite 120, Rancho Cucamonga, CA 91730
Tel. 1-877-273-4347, (TTY: 1-800-718-4347), Fax: 1-909-890-5748,
Email: CivilRights@iehp.org

Puede presentar una queja formal en persona o por correo postal, fax o correo electrónico. Si necesita ayuda para hacerlo, el Coordinador de Derechos Civiles está a su disposición para ayudarle.
DISCRIMINATION IS AGAINST THE LAW
LA DISCRIMINACIÓN ES UN ACTO CONTRA LA LEY

También puede presentar una queja de derechos civiles ante la Oficina de Derechos Civiles del Departamento de Salud y Servicios Humanos de los Estados Unidos de manera electrónica a través del Portal de Quejas de la Oficina de Derechos Civiles, disponible en https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, o bien, por correo postal a la siguiente dirección o por teléfono a los números que figuran a continuación:

U.S. Department of Health and Human Services,
200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-877-273-4347(TTY: 1-800-718-4347).

Español (Spanish)

لغة عربية (ARABIC)

Հայերեն (ARMENIAN)
Անհետացումը նայում է նույն լեզուն, սակայն այդ պայմանական որոշում, որ ծառայությունները աններում են: Համարեք 1-877-273-4347(TTY (հանրապետություն): 1-800-718-4347):

繁體中文 (CHINESE)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-877-273-4347 (TTY：1-800-718-4347)。

فارسی (FARSI)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان به شما آماده می باشند. با تماس بگیرید. (TTY: 1-877-273-4347 1-800-718-4347)

हिंदी (HINDI)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-877-273-4347(TTY: 1-800-718-4347) पर कॉल करें।

Rev. 9/2017
Hmoob (HMONG)

日本語 (JAPANESE)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-877-273-4347（TTY:1-800-718-4347）まで、お電話にてご連絡ください。

ភាសាខ្មែរ (KHMER)
ប្រការប្រការ: ប្រើប្រាស់ភាសាខ្មែរ (Khmer) ដែលជាព្រះពុគ្រោះ សម្រាប់ព័ត៌មាន 1-877-273-4347 (TTY: 1-800-718-4347)។

한국어 (KOREAN)

ພາສາລາວ (LAO)

ਪੰਜਾਬੀ (PUNJABI)
ਵਿਚਾਰਾਂ ਤੈਖੀ ਨੇ ਜੋ ਪੰਜਾਬੀ (Punjabi) ਵੇਲਦੇ ਤੇ, ਤੁਂ ਜੋ ਜ਼ਿੰਦਰੇ ਜ਼ਿੰਦਰੇ ਵਾਸ ਮਾਦਿਖਾਂ ਮੇਟਰੇ ਵਿੱਚਵਾਲਾ ਕਿਲੋ ਵੀਡਿਆ ਤਿੰਨ। 

Русский (RUSSIAN)

TAGALOG (TAGALOG – FILIPINO)

ภาษาไทย (THAI)

Tiếng Việt (VIETNAMESE)