**Template for**

**Notification of Non Covered Benefit Letter**

<<Date mailed>>

<<Member’s name>>

<<Street address>>

<<City>> <<State>> <<Zip Code>>

Dear <<Member Name>>

On <<Date>>, you requested <<Non-Covered Benefit>>. This letter is to inform you that the service/item you requested is/are not part of the Family Care benefit package and therefore <<name of the MCO>> will not be providing it to you.

If you have questions about this letter, please contact a member of your care team at the numbers listed below.

Sincerely,

<<Care Manager’s Name>>

Care Manager

<<Telephone Number>>

<<RN Care Manager’s Name>>

RN Care Manager

<<Telephone Number>>

**Who can help me understand this letter and my rights?**

<<Name of MCO>>’s member rights specialist can tell you about your rights and help you file a grievance. They often use informal meetings to resolve your issue. To contact a member rights specialist, call << member rights specialist phone number>>.

If you want to talk with someone outside of <<Name of MCO>>, contact an Ombudsman if you have any concerns. An Ombudsman is an advocate or helper. They can answer questions about grievances and tell you about your rights. Services are free and confidential. The organization to contact depends on your age.

**For members between the ages of 18 and 59**:

Disability Rights Wisconsin

Toll Free: 800-928-8778

TTY: 711

Email: [info@drwi.org](mailto:info@drwi.org)

**For members 60 and older**:

Wisconsin Board on Aging and Long Term Care

Toll Free: 800-815-0015

TTY: 711

Email: [BOALTC@wisconsin.gov](mailto:BOALTC@wisconsin.gov)