County of Alameda
Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION
(Denial of Provider Request for Service)

To: | | Date:

CIN #:

The mental health plan for Alameda County has ☐ denied ☐ changed your provider's request for payment of the following service(s): _____
_____

The request was made by: _____ .

The original request from your provider was dated _____.

The mental health plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
_____
_____

☐ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).

☐ The mental health plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The mental health plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____
_____

☐ Other _____
_____

If you don't agree with the plan's decision, you may:

1. You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at 1.800.779.0787, or write to Consumer Assistance, 2000 Embarcadero Cove, Suite 400, Oakland, CA 94606, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions. You can request that your services stay the same until an appeal decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____ . The effective date for the change in these services is _____ .

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing which may allow services to continue while you wait for the hearing. The other side of this notice explains how to request a hearing. You can request that your services stay the same until a hearing decision is made. To keep your services you must file an appeal within 10 days of the date of this notice or before the effective date of the change in services, whichever is later. The services requested were previously approved by the plan for the period _____ . The effective date for the change in these services is _____. The services may continue while you wait for a resolution of your hearing.

3. You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at 1.800.481.9099 or write to ACCESS, 1900 Embarcadero Cove, Suite 208, Oakland, CA 94606.