Behavioral Health Department
Alameda County Health

Karyn Tribble, PsyD, LCSW
Director

NOTICE OF ADVERSE BENEFIT DETERMINATION-Financial Liability

About Your Financial Liability

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: ***Service requested***

Plan has denied your dispute of financial liability regarding *insert a description of the disputed financial liability (e.g., cost-sharing, co-insurance, other liabilities)*. This is because *Using plain language, insert a clear and concise explanation of the reasons for the denial. If further information is need, indicate what further information is needed and/or additional steps need be taken, if necessary*.

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call *Plan* at *telephone number*.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *Plan's Member Services telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you

would like help reading the material, please contact *Plan* by calling *telephone number*.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

Signature Block

Enclosed: "Your Rights"
Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

2000 Embarcadero Cove, Oakland, CA 94606, Suite 400 | Health.AlamedaCountyCA.gov/ACBHD | 1-510-567-8100 (TTY: 1-510-533-5018)