ATTACHMENTS
Policy: Notices of Adverse Benefit Determination for Medi-Cal Beneficiaries

A. NOABD- Denial (of Authorization) Template

B. NOABD- Payment Denial Template

C. NOABD- Delivery System Template

D. NOABD- Modification Template

E. NOABD- Termination Template

F. NOABD-Authorization Delay Template

G. NOABD- Timely Access Template

H. NOABD- Financial Liability Template

I. NOABD- Grievance & Appeal Timely Resolution Template

J. Beneficiary Enclosures:
   - NOABD Your Rights Attachment
   - Language Assistance Taglines Attachment
   - Nondiscrimination Notice Attachment

K. NOABD Table

alameda county behavioral health
SERVICES FOR MENTAL HEALTH & SUBSTANCE USE DISORDERS

2000 Embarcadero Cove, Suite 400
Oakland, California 94606
510-567-8100 / TTY 510-533-5018
Carol F. Burton, MSW, Interim Director

NOTICE OF ADVERSE BENEFIT DETERMINATION- Denial

About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Name of requestor has asked *Plan* to approve *Service requested*. This request is denied. The reason for the denial is *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.*
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*.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter or before the date the Plan says services will be stopped or reduced.

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

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

Enclose notice with each letter

alameda county behavioral health
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NOTICE OF ADVERSE BENEFIT DETERMINATION- Payment Denial
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Name of requesting provider has asked *Plan* to approve payment for the following service, which you already received: *Service requested*. The Plan has denied your provider's request for payment. The reason for the denial is *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity*.

Please note: this is not a bill for the service. You are not required to pay for the services you received.

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.

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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.

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Signature Block

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NOTICE OF ADVERSE BENEFIT DETERMINATION- Delivery System
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

This notice lets you know that *Mental Health Plan* has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services. *Using plain language, insert: 1. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and, 2. The clinical reasons for the decision regarding medical necessity*.

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from *Health Plan or Entity responsible for mental health services, e.g., physical health care provider*. You can call them at *telephone number. **If applicable, insert additional action taken by the Mental Health Plan to coordinate care and/or additional follow-up needed by the Member**.*

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*.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the

date on this letter, or before the date your mental health plan says services will be stopped or reduced.

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

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NOTICE OF ADVERSE BENEFIT DETERMINATION- Modification
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

Name of requestor has asked *Plan* to approve *Service requested.* We cannot approve this treatment as requested. This is because *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity*.

We will instead approve the following treatment: *Service or service length approved.*

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*.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your mental health plan says services will be stopped or reduced.

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

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Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

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NOTICE OF ADVERSE BENEFIT DETERMINATION-Termination
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You are currently receiving *Service to be terminated.* Beginning on *termination date* we will no longer approve this treatment. This is because *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity*.

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*.

If you want to keep getting this service while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your plan says services will be stopped or reduced, listed above.

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

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.

Signature Block

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

Enclose notice with each letter

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NOTICE OF ADVERSE BENEFIT DETERMINATION- Timely Access
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider [Name of requesting provider has asked *Plan* to obtain or approve *Service requested*. The *Plan or Name of requesting provider* has not provided services within *number of* working days. Our records show that you requested service(s), or service(s) were requested on your behalf on *date requested.*

We apologize for the delay in providing timely services. We are working on your request and will provide you with *Service requested* soon.

You may appeal this decision. 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.

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.

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Signature Block

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Beneficiary Non-Discrimination Notice

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Carol F. Burton, MSW, Interim 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

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NOTICE OF ADVERSE BENEFIT DETERMINATION- Authorization Delay
About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or your provider (Name of requesting provider) has asked *Plan* to obtain or approve *Service requested*. Our records show that you requested service(s), or service(s) were requested on your behalf on *date requested*. The *Plan* has not yet made a decision about the request.

We apologize for the delay in processing this request. We are working on your request and will provide *you or your provider (Name of requesting provider)* with a decision as soon as possible.

You may appeal this decision. 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.

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)

alameda county behavioral health
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NOTICE OF ADVERSE BENEFIT DETERMINATION
Grievance & Appeal Timely Resolution

About Your Treatment Request

Date

Beneficiary's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *[Service requested]*

Our records show that you filed a *grievance or appeal* with the *Plan or (Name of provider)* on *date filed.* Unfortunately, the *Plan* did not finish reviewing the *grievance or appeal* within the required timeline.

We apologize for the delay in processing your *grievance or appeal*. We are working on it and will provide you with a decision as soon as possible.

You may appeal this decision. 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.

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 need hearing or speaking assistance, please call California Relay Service at *711*, between *hours of operation* for help.

For help with Mental Health or Substance Use Disorder services, please call ACCESS toll free 24hrs a day/7 days a week at 1-800-698-1118.

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* 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.

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Signature Block

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Beneficiary Non-Discrimination Notice

Enclose notice with each letter

NONDISCRIMINATION NOTICE

Discrimination is against the law. *Plan* follows Federal civil rights laws. *Plan* does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

Plan provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
    - Qualified sign language interpreters
    - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- 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 *Plan* 24 hours a day, 7 days a week by calling *telephone number.* Or, if you cannot hear or speak well, please call the CA Relay Service at 711.

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 YOU DO NOT AGREE WITH THE DECISION MADE FOR YOUR MENTAL HEALTH OR SUBSTANCE USE DISORDER TREATMENT, YOU CAN FILE AN APPEAL. THIS APPEAL IS FILED WITH YOUR PLAN.

HOW TO FILE AN APPEAL

You have **60 days** from the date of this "Notice of Adverse Benefit Determination" letter to file an appeal. **If you are currently getting treatment and you want to keep getting treatment, you must ask for an appeal within 10 days** from the date on this letter OR before the date your Plan says services will stop. You must say that you want to keep getting treatment when you file the appeal.

You can file an appeal by phone or in writing. If you file an appeal by phone, you must follow up with a written signed appeal. The Plan will provide you with free assistance if you need help.

- To appeal by phone: Contact Consumer Assistance between 9am -5pm Mon-Fri by calling 1-800-779-0787. Or, if you have trouble hearing or speaking, please call 711.

- To appeal in writing: Fill out an appeal form or write a letter to your plan and send it to:

  Consumer Assistance
  2000 Embarcadero Ste. 400
  Oakland, CA 94606

  Your provider will have appeal forms available. Consumer Assistance can also send a form to you.

You may file an appeal yourself. Or, you can have someone like a relative, friend, advocate, provider, or attorney file the appeal for you. This person is called an "authorized representative." You can send in any type of information you want your Plan to review. Your appeal will be reviewed by a different provider than the person who made the first decision.

Your Plan has 30 days to give you an answer. At that time, you will get a "Notice of Appeal Resolution" letter. This letter will tell you what the Plan has decided. **If you do not get a letter with the Plan's decision within 30 days, you can ask for a "State Hearing" and a judge will review your case**. Please read the section below for instructions on how to ask for a State Hearing.

EXPEDITED APPEALS

If you think waiting 30 days will hurt your health, you might be able to get an answer within 72 hours. When filing your appeal, say why waiting will hurt your health. Make sure you ask for an "**expedited appeal."**

STATE HEARING

If you filed an appeal and received a "Notice of Appeal Resolution" letter telling you that your Plan will still not provide the services, or **you never received a letter telling you of the decision and it has been past 30 days,** you can ask for a "State Hearing" and a judge will review your case. You will not have to pay for a State Hearing.

You must ask for a State Hearing within **120 days** from the date of the "Notice of Appeal Resolution" letter. You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.

- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx

- In writing: Fill out a State Hearing form or send a letter to:

  California Department of Social Services
  State Hearings Division
  P.O. Box 944243, Mail Station 9-17-37
  Sacramento, CA 94244-2430

  Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will hurt your health, you might be able to get an answer within 3 working days. You may want to ask your provider or Plan to write a letter for you, or you can write one yourself. The letter must explain in detail how waiting for up to 90 days for your case to be decided will seriously harm your life,

your health, or your ability to attain, maintain, or regain maximum function. Then, ask for an **"expedited hearing"** and provide the letter with your request for a hearing.

Authorized Representative

You may speak at the State Hearing yourself. Or someone like a relative, friend, advocate, provider, or attorney can speak for you. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak for you. This person is called an "authorized representative."

LEGAL HELP

You may be able to get free legal help. You may also call the local Legal Aid program in your county at 1-888-804-3536.

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (TTY: 711).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (TTY: 711).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (TTY: 711).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (TTY: 711).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 711 (TTY:).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

(TTY: 711) 번으로 전화해 주십시오.

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

(TTY: 711)。

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (TTY: 711).

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (TTY: 711).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) تماس بگیرید.

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。 (TTY: 711) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (TTY: 711).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (رقم هاتف الصم والبكم: 711 *(TTY:*

हिंदी (Hindi)
ध्यान दें यिद आप हिंदी बोलते हैं तो आपकेलिए मुफ्त में भाषा सहायता सेवाएंउपलब्ध हैं। (TTY: 711) पर कॉल करें

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (TTY: 711).

ខ្មែរ (Cambodian)

ប្រ្របយ័ត្នះររ ររើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា រ
រាយមិនគិត្ួ្លួន គឺអាចមានសំរា ់ ំររ អេ្ិ នក។ ចូ ទូ ស័ព្ទ
(TTY:711) ។

ພາສາລາວ (Lao)

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (TTY: 711).

Send with all notices

HOW TO FILE A GRIEVANCE

If you believe that *Plan* 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 *Plan.* You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Consumer Assistance between 9am to 5pm Mon-Fri by calling 1-800-779-0787. Or, if you cannot hear or speak well, please call 711.

- In writing: Fill out a grievance form, or write a letter and send it to:

  Consumer Assistance
  2000 Embarcadero Cove, Suite 400
  Oakland, CA 94606

- In person: Visit your provider's office or *the Mental Health Association, 954 60th Street, Suite 10, Oakland, CA 94608* and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

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

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) TABLE
For Medi-Cal Beneficiaries: Specialty Mental Health and Substance Use Disorder Treatment Services

An Adverse Benefit Determination is defined to mean any of the following actions taken by the Behavioral Health Plan (BHP), which includes Alameda County Behavioral Health (ACBH) and ACBH-contracted providers:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. The reduction, suspension, or termination of a previously authorized service;
3. The denial, in whole or in part, of payment for a service;
4. The failure to provide services in a timely manner;
5. The failure to act within the required timeframes for standard resolution of grievances and appeals; or
6. The denial of a beneficiary's request to dispute financial liability.

Beneficiaries must receive a written NOABD when the BHP takes any actions described above.

- NOABDs sent to beneficiaries shall include all of the following enclosures:
  - NOABD "Your Rights"
  - Language Assistance Taglines
  - Beneficiary Nondiscrimination Notice

- ACBH-contracted providers are required to send copies of NOABDs to:

ACBH Quality Assurance (QA) Office
2000 Embarcadero Cove, Suite 400 or FAX to: (510) 639-1346
Oakland, CA 94606

NOTICE OF ADVERSE BENEFIT DETERMINATION (NOABD) TABLE
For Medi-Cal Beneficiaries: Specialty Mental Health and Substance Use Disorder Treatment Services

NOABD	Who Issues Notice?	Who Receives Notice?	Criteria for Beneficiary Notice
Denial (of Authorization) Notice	BHP: ACBH and ACBH-contracted providers	Beneficiary or parent/legal guardian, ACBH QA	The BHP denies a request for a service. Denials include determinations based on type or level of service, requirements for medical necessity, appropriateness, setting or effectiveness of a covered benefit. The BHP must mail the notice to the beneficiary within two (2) business days of the decision.
Payment Denial Notice	ACBH	Beneficiary or parent/legal guardian	ACBH denies, in whole or in part, for any reason, a provider's request for payment for a service that has already been delivered to a beneficiary. ACBH must mail the notice to the beneficiary at the time of any action denying the provider's claim.
Delivery System Notice	ACBH	Beneficiary or parent/legal guardian	ACBH has determined that the beneficiary does not meet the criteria to be eligible for specialty mental health services (SMHS). The beneficiary will be referred to the Managed Care Plan, or other appropriate system, for mental health and/or other services. The Plan must mail the notice to the beneficiary within two (2) business days of the decision. NOTE: This template does not apply to SUD services.
Modification Notice	BHP: ACBH and ACBH-contracted providers	Beneficiary or parent/legal guardian; ACBH QA	The BHP modifies or limits a provider's request for a service, including reductions in frequency and/or duration of services, and approval of alternative treatments and services. The BHP must mail the notice to the beneficiary within two (2) business days of the decision. Requires provider notification within 24 hours.[1]
Termination Notice	BHP: ACBH and ACBH-contracted providers	Beneficiary or parent/legal guardian; ACBH QA	The BHP terminates, reduces or suspends a previously authorized service. The BHP must mail the notice to the beneficiary at least ten (10) days before the date of the action. Requires provider notification within 24 hours.[1]
Authorization Delay Notice	ACBH	Beneficiary or parent/legal guardian	When there is a delay in processing a provider's request for authorization of specialty mental health services or substance use disorder residential services. When ACBH extends the timeframes to make an authorization decision, it is a delay in processing a provider's request. This includes extensions granted at the request of the beneficiary or provider, and/or those granted when there is a need for additional information from the beneficiary or provider, when the extension is in the beneficiary's interest. ACBH must mail the notice to the beneficiary within two (2) business days of the decision.
Timely Access Notice	BHP: ACBH and ACBH-contracted providers	Beneficiary or parent/legal guardian; ACBH QA	When there is a delay in providing the beneficiary with timely services, as required by the timely access standards applicable to the delayed service. The BHP must mail the notice to the beneficiary within two (2) business days.
Financial Liability Notice	ACBH	Beneficiary or parent/legal guardian	ACBH denies a beneficiary's request to dispute financial liability, including cost-sharing and other beneficiary financial liabilities. ACBH must mail the notice to the beneficiary at the time of any action regarding the dispute.
Grievance & Appeal Timely Resolution	BHP: ACBH and ACBH-contracted providers	Beneficiary or parent/legal guardian; ACBH QA	Failure to timely resolve grievances and/or appeals. Use this template when the BHP does not meet required timeframes for the standard resolution of grievances and appeals.

NOTE: The BHP must also communicate the decision to the affected provider within 24 hours of making the decision, initially by telephone or facsimile, and then by writing, except for decisions rendered retrospectively.[1] Services that are reduced, modified, or terminated by outpatient providers that are not subject to prior authorization and are the result of a treatment Team/Clinician decision based on the beneficiary's clinical condition and/or progress in treatment is not subject to an adverse benefit determination notification. The beneficiary still has the right to appeal the decision with the BHP even if a NOABD is not received.