

**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 receive.

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

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

Enclose notice with each letter