



**Behavioral Health
Department**

Alameda County Health

Karyn Tribble, PsyD, LCSW

Director

**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