Enclosure 6

NAME

ADDRESS

ADDRESS

Beneficiary Reimbursement Reference Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dear Mr. NAME:

This letter is about the Good Cause Notification letter, dated XX/XX/XX, that was sent to you. Included with this notification was a Request For An Administrative Review For Determination Of Good Cause For Untimely Filing Of An Old Medi-Cal Claim Form For Beneficiary Reimbursement Form. You had 90 days from the date of that letter to submit a request for an administrative review for determination of good cause for untimely filing of an old claim for Medi-Cal beneficiary reimbursement if you believed your late filing was due to “good cause”.

It has been over 90 days since the date of that letter. DMH has not received a request from you for administrative review for determination of good cause for untimely filing of your old claim for Medi-Cal beneficiary reimbursement. Therefore, your claim is considered untimely and is denied.

If you do not agree with this decision, you have the right to request a State Hearing. You must make this request within 90 days of the date of this letter (the date at the top of the letter). Information for a State Hearing may be found attached to this notice.

For answers to your questions call the Beneficiary Service Center at (916) 403-2007. For TDD telephone service call (916) 635-6491.

Sincerely,

SIGNATURE BLOCK

Authority: Welfare and Institutions Code, Section 14019.3.

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| BENEFICIARY REIMBURSEMENT FOR MEDICAL/DENTAL CARE YOUR HEARING RIGHTSYou have a right to ask for a State Hearing about this Medi-Cal action. (California Code of Regulations, Title 22, Section 50951). You must ask for a State Hearing within 90 days of the date this notice was mailed to you.HOW TO ASK FOR A STATE HEARINGThe best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to: State Hearings Division California Department of Social Services P.O. Box 944243, Mail Station 19-99 Sacramento, CA 94244-2430Another way to ask for a hearing is to call 1-800-952-5253. For TDD telephone service call 1-800-952-8349.You have the right to examine the materials that were used to take this Medi-Cal action and may arrange this by contacting the Beneficiary Services at (916) 403-2007. For TDD telephone service call (916) 635-6491. **State Regulations Available** State regulations, including those covering state hearings, are available at your local county welfare office or on the Internet at www.calregs.com.To Get HelpYou may get free legal help at your local legal aid office or other groups. To ask about getting free legal help to represent you at your hearing, look under “Legal Services” in the Yellow Pages of your local telephone book.Authorized RepresentativeYou can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself. **Note:** The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete.  | BENEFICIARY REIMBURSEMENT HEARING REQUESTI want a hearing because I paid for a medical service and my health care provider would not give back my money.**Comments**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  Check here and add a page if you need more space.**My name: (print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**My Medi-Cal Number:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**My Address: (print)** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**My phone number:** (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  I need an interpreter at no cost to me. My language or dialect is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ]  I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone number: (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**My signature (claimant):** **X**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date signed**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |