MEDI-CAL NOTICE OF ACTION
DENIAL/DISCONTINUANCE OF BENEFITS

(County Stamp)

Notice date: _____
Case number: _____
Worker name: _____
Worker number: _____
Worker telephone number: _____
Office hours: _____
Notice for: _____

We have reviewed all information available to us about your circumstances, and we find that:

❒ Your application for Medi-Cal, dated _____, has been denied.
(Month Day Year)

❒ Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____.
(Month)

DO NOT THROW YOUR PLASTIC ID CARD AWAY. You can use it again if you become eligible for Medi-Cal.

The reason for this denial/discontinuance is:

The regulations which require this action are California Code of Regulations, Title 22, Section(s):

If you are eligible for Medicare and your Medi-Cal eligibility is discontinued, this means that _____ is the last month the State will pay your premium for supplementary insurance coverage (Part B Medicare). You will receive a written notice from the Social Security Administration, or you may call your Social Security district office if you have any questions about your Medicare Status.

If you have any questions about this action or if there are additional facts relating to your circumstances which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you in person. Please remember that this action pertains only to the circumstances you reported to us, and that you may reapply at any time.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE