*Plan Letterhead*

# NOTICE OF APPEAL RESOLUTION

#### Date

## *Member’s Name* *Treating Provider’s Name*

*Address* *Address*

*City, State Zip* *City, State Zip*

### RE: *Service requested*

You or*Name of requesting provider or authorized representative*,on your behalf, appealed the *denial, delay, modification, or termination* of *Service requested.* *Plan*has reviewed the appeal and has decided to overturn the original decision. This request is now approved. 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*.

*Plan or Provider* is required to authorize or provide you with the service within 72 hours.

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*