ENCLOSURE 3

Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION
(Assessment)

Date: _____

To: _____, Medi-Cal Number _____

The mental health plan for _____ County has decided, after reviewing the results of an assessment of your mental health condition, that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services through the plan.

In the mental health plan's opinion, your mental health condition did not meet the medical necessity criteria, which are covered in the state regulations at Title 9, California Code of Regulations (CCR), Section 1830.205, for the reason checked below:

☐ Your mental health diagnosis as identified by the assessment is not covered by the mental health plan (Title 9, CCR, Section 1830.205(b)(1)).

☐ Your mental health condition does not cause problems for you in your daily life that are serious enough to make you eligible for specialty mental health services from the mental health plan (Title 9, CCR, Section 1830.205(b)(2)).

☐ The specialty mental health services available from the mental health plan are not likely to help you maintain or improve your mental health condition (Title 9, CCR, Section 1830.205(b)(3)(A) and (B)).

☐ Your mental health condition would be responsive to treatment by a physical health care provider (Title 9, CCR, 1830.205(b)(3)(C)).

If you agree with the plan's decision, and would like information about how to find a provider outside the plan to treat you, you may call and talk to a representative of your mental health plan at _____ or write to:
_____
_____.

If you don't agree with the plan's decision, you may do one or more of the following:

You may ask the plan to arrange for a second opinion about your mental health condition. To do this, you may call and talk to a representative of your mental health plan at _____ or write to: _____
_____.

You may file an appeal with your mental health plan. To do this, you may call and talk to a representative of your mental health plan at _____ or write to: _____
_____, or follow the directions in the information brochure the mental health plan has given you. You must file an appeal within 90 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 45 days of your request. You may request an expedited appeal, which must be decided within 3 working days, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at _____ or write to: _____
_____

If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The other side of this form will explain how to request a hearing.

NOA-A (revised 61-05)