

DEPARTMENT OF HEALTH CARE SERVICES

Se le puede enviar una traducción de esta forma si la pide por escrito a la oficina que se menciona a la izquierda.



NOTICE OF ACTION (Modified/Deferred)

To: _____

Signature

Date

Medi-Cal Number: _____

The _____ Medi-Cal Field Office has returned or modified your doctor's or other Medical provider's request for medical payment of the following service(s): _____

The request for Medi-Cal payment was made by: Provider name: _____
Address: _____ Phone number: _____

The request for Medi-Cal payment was returned or modified for the reason(s) in the paragraph checked below:

1. The request for Medi-Cal payment was returned to the provider shown at the top of this notice. Additional information is needed regarding your medical condition and/or medical requirements before the Medi-Cal medical consultant can decide whether to approve the request for Medi-Cal payment of proposed services [California Code of regulations, Title 22, Section 51003(d)]. If you have not heard from your provider (named above) within 30 days from the date of this letter regarding this request for payment for services, it is suggested that you contact your provider. If you do not receive a satisfactory response from your provider, you may contact the Medi-Cal Field Office (see address and telephone number above.)
2. The request for Medi-Cal payment of proposed services has been returned to the provider shown at the top of this notice. It has been returned because of the possibility that other medical coverage, namely _____, may cover the cost of the proposed services(s)—[California Code of Regulation, Title 22, Section 51005(a)].

The Medi-Cal Field Office cannot make a decision as to whether or not to pay for the proposed service(s) without this other medical coverage information. Therefore, we are requesting verification of other medical coverage. If you have not heard from your provider (named above) regarding this request for Medi-Cal payment for the proposed services, it is suggested that you contact your provider. If you do not receive a satisfactory response from your provider, you may contact the Medi-Cal Field Office (see address and telephone number above.)

3. The request for Medi-Cal payment of proposed services has been changed (modified). The changes were made based on the available information regarding your medical condition and medical needs. Medi-Cal will pay for the following service(s)/equipment instead:

[California Code of Regulations, Title 22, Section 51003(e)]

If you have any questions about these changes, you may wish to contact your provider (named above).

4. Other:

If you are dissatisfied or concerned with the above action, you also may request a state hearing. Your right to request a state hearing is explained on the reverse side of this notice.

Original—Beneficiary; **Copy**—Provider/Field Office/Headquarters