[Plan Letterhead]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member’s Name]
[Address]
[City, State Zip]

[Treating Provider’s Name]
[Address]
[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.

[County Grievance Team]

Enclosed*: "Your Rights under Medi-Cal Managed Care"*
Language Assistance Taglines

[Enclose notice with each letter]