

# *“Payment Denial”*

[Plan Letterhead]

## **NOTICE OF ADVERSE BENEFIT DETERMINATION About Your Treatment Request**

[Date]

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

[Treating Provider's Name]  
[Address]  
[City, State Zip]

**RE:** [Service requested]

[Name of requesting provider] has asked [Plan] to approve payment for the following service, which you already received: [Service requested]. The Plan has denied your provider's request for payment. The reason for the denial is [Using plain language, insert for the following three requirements:

1. A clear and concise explanation of the reasons for the decision;
2. A description of the criteria or guidelines used, including a citation to the specific regulations and authorization procedures that support the action; and
3. The clinical reasons for the decision regarding medical necessity].

**Please note: this is not a bill for the service. You are not required to pay for the services you received.**

You may appeal this decision if you think it is incorrect. The enclosed “Your Rights” information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed “Your Rights” information notice provides timelines you must follow when requesting an appeal.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that we used to make our decision. To ask for this, please call [Plan] at [telephone number].

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.

This notice does not affect any of your other Medi-Cal services.

*[County Grievance Team]*

Enclosed: Your Rights under Medi-Cal Managed Care  
Language Assistance Taglines  
Member Non-Discrimination Notice

*[Enclose notice with each letter]*