

“Modification”

[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 requestor] has asked *[Plan]* to approve *[Service requested]*. We cannot approve this treatment as requested. This is because *[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 reference to the specific regulations or plan authorization procedures that support the action; and*
- 3. The clinical reasons for the decision regarding medical necessity].*

We will instead approve the following treatment: *[Service or service length approved]*.

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]*.

If you are currently getting services and you want to keep getting services while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your mental health plan says services will be stopped or reduced.

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

[Enclose notice with each letter]