

# *“Authorization Delay”*

*[County 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]*

*[You or your provider (Name of requesting provider)]* has asked *[County]* to obtain or approve *[Service requested]*. Our records show that you requested service(s), or service(s) were requested on your behalf on *[date requested]*. The *[Plan]* has not yet made a decision about the request.

We apologize for the delay in processing this request. We are working on your request and will provide *[you or your provider (Name of requesting provider)]* with a decision as soon as possible.

You may appeal this decision. 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.

The County can help you with any questions you have about this notice. For help, you may call *[County] [hours of operation]* at *[County’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 County 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 *[County]* by calling *[telephone number]*.

If the County 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]*