

[Insert Logo]

Address
 City, State, ZIP
 Telephone Number
 TTY/TDD Number

{Date}

{Participant's Name or Representative}
 {C/o Participant's Name}
 {Address}

RE: **Notice of Action (NOA) for Service or Payment Request**

Dear Mr/s {Name}:

Your request of [insert date] for [insert brief description of requested service or payment for service]

Has been: **Denied** **Deferred** **Modified** for the reason(s) indicated below:

- Is not determined necessary by the Interdisciplinary Team (IDT)
- Requested services will not improve or contribute to sustaining your health
- An alternative service is provided to meet your care needs
- Did not meet authorization criteria
- Requires additional information or consult
- Requested service has potentially negative health and safety issues
- Other (please describe): _____

This decision was based on the following criteria or clinical guidelines:

If you do not agree with the action above, you have the right to appeal the decision. Please see the attached "*Information for Participants about the Appeals Process*" for your right to request further action. You may call your social worker or our [Quality Assurance Department or designee] at [insert telephone number] who will explain these processes to you. For the hearing impaired (TTY/TDD), please call [insert number].

Sincerely,

[Director or IDT Member], [Professional Discipline]

/enclosure

cc: [Name and Address of Treating Provider]