[Plan Letterhead]

NOTICE OF GRIEVANCE RESOLUTION

[Date]

[Members Name]
[Address]
[City, State Zip]

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

RE: YOUR GRIEVANCE

You or *[Name of requesting provider or authorized representative]*, on your behalf, filed a grievance with the *[Plan]* on *[DATE]***.** [*Plan]* has reviewed your grievance. This notice describes steps taken to resolve your grievance.

[Using plain language, insert for the following four requirements:
1. A summary of the grievance filed by the member;
2. Steps taken to resolve the grievance (e.g., investigation, speaking with provider);
3. A clear and concise explanation of how the grievance was resolved, including if it was resolved in favor of the member; and,
4. The reasons for the decision.]

If you are dissatisfied with the resolution of your grievance, you may file another grievance with the *[Plan]*.

The Plan can help you with any questions you have about this notice. For help, you may call *[Plan] [hours of operation]* at *[24/7 toll-free 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]