"Adverse Benefit Determination Upheld"

[Plan Letterhead]

NOTICE OF APPEAL RESOLUTION

[Date]

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

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

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]*, on your behalf, appealed the *[denial, delay, modification, reduction or termination or other adverse benefits determination]* of *[Service requested]. [Plan]* has reviewed the appeal and has decided to uphold the decision. This request is still denied. This is because *[Using plain language, insert: 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]*.

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

You may appeal this decision by requesting a State Hearing. 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 in any information that could help your case. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal, and your right to request that the Plan continue to provide you with treatment during the State Hearing process. You will not be held liable for the cost of continued treatment if the State Hearing decision upholds the Plan's adverse benefit determination.

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.

[County Grievance Team]

Enclosed*: “Your Rights under Medi-Cal Managed Care”*
Language Assistance Taglines

[Enclose notice with each letter]