

“Adverse Benefit Determination Overturned”

[County 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, or termination] of [Service requested]. [County] has reviewed the appeal and has decided to overturn the original decision. This request is now approved. 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 county authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity].

[County or Provider] is required to authorize or provide you with the service within 72 hours.

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.

[County Grievance Team]

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

[Enclose notice with each letter]