*[**Plan Letterhead]*

# NOTICE OF GRIEVANCE RESOLUTION

#### [Date]

## *[**Members Name] [**Treating Provider’s Name]*

*[**Address] [**Address]*

*[**City, State Zip] [**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: 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.

*[Medical Director’s Name]*

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

 Language Assistance Taglines

*[**Enclose notice with each letter]*