[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]. Please note that DHCS treats all participant information included in the appeal process as confidential.

Sincerely,

[Director or IDT Member], [Professional Discipline]

/enclosure

cc: [Name and Address of Treating Provider]