<<IPA LOGO>>

NOTICE OF ACTION
About Your Treatment Request

<Date>

<Member's Name>
<Address>
<City, State Zip>

<Treating Provider's Name>
<Address>
<City, State Zip>

Identification Number: <Reference Number>

RE: <Service requested>

Dear <Member name>,

We hope you're doing well. We're writing to let you know that <Name of requesting provider> asked <<IPA>> to approve <Service requested>, but we had to deny this request.

This decision was made because: <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 have the right to see the information we used to make this decision. To ask for a free copy, call << IPA>> at <<IPA Phone Number>>, << IPA Phone Hours and Days>> << IPA TTY Phone Number>>.

What You Can Do
You can appeal this decision if you disagree. The enclosed "Your Rights" information letter tells you how to do this, including deadlines and how to get free help, like free legal support. You can also send any information that might help your case.

For help with Medi-Cal, you may call the California Department of Health Care Services (DHCS) Ombudsman Office at **1-888-452-8609**, Monday through Friday, 8:00am to 5:00pm, excluding holidays. The Ombudsman Office helps people with Medi-Cal understand their rights and responsibilities. You can also get help from your doctor.

Please know that this decision does not change any other Medi-Cal care you have.

If you have any questions, please call us at <<IPA Phone Number>>, << IPA Phone Hours and Days>> << IPA TTY Phone Number>>.

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Sincerely,

<IPA>

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