DATE

SENT VIA FEDEX

Provider First Name M.I. Last Name Suffix, Degree
c/o Practice Name
Address
City, STATE ZIP

RE: IEHP CREDENTIALING SUBCOMMITTEE DECISION

Dear Provider Name:

Inland Empire Health Plan (IEHP)'s Credentialing Subcommittee met on **(DATE)**, and reviewed (REASON FOR REVIEW).

Due to evidence documenting (EVIDENCE FOUND), the IEHP Credentialing Subcommittee has made the recommendation to terminate/deny/suspend your participation with IEHP Direct.

You have the right to appeal this recommendation and request a first level appeal, which is held before the IEHP Credentialing Subcommittee. If you wish to request an appeal, your written request must be received within thirty (30) days of receipt of this letter. In a Level I Review, you will have the right to be present and participate in the proceedings. If you request an appeal, please provide copies of any additional information, which you would like to have presented at the Credentialing Subcommittee meeting for your appeal. In addition, please let me know if you wish to be present at the meeting by contacting me at (PHONE NUMBER). Please send your written request to:

Inland Empire Health Plan
Attn: [Credentialing Chairperson Name]
P.O. Box 1800
Rancho Cucamonga, CA 91729

If your written request for appeal is not received within thirty (30) days of your receipt of this notice, your rights will be considered waived, and any action recommended by the Credentialing Subcommittee will be presented to the Governing Board of IEHP for final action.

A copy of the IEHP Peer Review (Level I) and Credentialing Policy and Procedures is enclosed for your information and further clarification of your rights in the Level I appeal process.

IEHP will report the final decision of the IEHP Governing Board, to the Medical Board of California and/or the National practitioner Data Bank, as required under California business and professions Codes subsection 805 and 45 of Federal Regulations, Part 60.

Should you wish to discuss this matter further, please feel free to contact [CREDENTIALING CHAIRPERSON'S NAME] at [PHONE NUMBER] or [EMAIL].

Sincerely,

IEHP MEDICAL DIRECTOR'S NAME
Medical Director, IEHP
Credentialing Subcommittee Chairperson

Enclosures: IEHP Peer Review Level I and Credentialing Appeal

cc: [NAME], Chief Operating Officer, IEHP
[NAME], Chief Medical Officer, IEHP
[NAME], Director of Provider Relations, IEHP
[NAME], Director of Provider Network, IEHP
[NAME], Medical Director, IEHP
[NAME], Director of Quality Management
[NAME], Provider Services Representative, IEHP
[NAME], Credentialing Manager, IEHP
[NAME], Credentialing Contact Title, IPA NAME
[NAME], Medical Director, IPA NAME
Provider File