<IPA LOGO>

NOTICE OF ACTION – CARVE OUT
About Your Treatment Request

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

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

Identification Number: <<Member ID Number>>; Case #: <<Insert case number>>

RE: << Service Requested>>

This is NOT a denial of services.

This letter tells you that <IPA name> cannot provide the care you asked for (shown above).

You can get the care from <Entity responsible for carved-out service>. You can call them at <telephone number>. You can also contact <IPA> and we will help you get the care you need and contact <Entity responsible for carved-out service>. <Insert additional action taken by the Health Plan to coordinate care and/or additional follow-up needed by the Member>.

The State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You can call them at **1-888-452-8609**. You can also get help from your Doctor, or call <IPA Contact> at **<IPA phone and hours of operation>**. TTY users should call 711.

This letter does not change your other Medi-Cal care.

< Medical Director's Name or Reviewer's Name>