< IPA LOGO >

NOTICE OF ACTION – MODIFY
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 #: <<Member ID Number>>; Case #: <<Insert case number>>

RE: <<Service requested>>

<Name of requesting provider> has asked <IPA name> to approve *<Service requested>.* We cannot approve this treatment the way it is. This is 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>*.

We have instead approved: *<Clear and concise explanation of modification of request and service approved>.*

You can get free copies of all information used to make this decision. To ask for this, please call <IPA name, phone number and hours of operation>.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You may call them at 1-888-452-8609. You may also get help from your doctor, or call IEHP Member Services at **1-800-440-IEHP (4347)**, Monday-Friday, 7 a.m.–7 p.m., and Saturday–Sunday, 8 a.m.–5 p.m. TTY users should call **1-800-718-4347**.

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

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care

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