<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>

<Name of requesting provider> has asked <IPA> to approve <Service requested>. This request is denied. 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>.

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

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 can call them at 1-888-452-8609. You can also get help from your Doctor, or call IEHP Member Services at 1-800-440-IEHP (4347), Monday–Friday, 7am–7pm, and Saturday–Sunday, 8am–5pm. 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"