[Health Plan or PPG Letterhead]

"Carve-Out"

[Health Plan or PPG Tracking Number – optional]

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

RE: *[Service requested]*

This is NOT a denial of services.

This notice lets you know that *[Medical group/IPA name]*, under contract with *[Health Plan]*, is not responsible for providing or authorizing the service(s) shown above.

You can get the service directly from *[Entity responsible for carved-out service]*. You can call them at *[telephone number]*. *[Health Plan]* will assist you with coordinating care and has contacted *[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].*

You may appeal this decision if you think it is incorrect. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get free help. This also means free legal help. You are encouraged to send in any information that could help your case. The "Your Rights" notice tells you the cut off dates to 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 us at *[Health Plan's Member Services telephone number]*.

This notice does not affect any of your other Medi-Cal services.

[Medical Director's Name]

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

(Enclose notice with each letter)