[Health Plan or PPG Letterhead] "Delay"

[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]*

[Name of requesting provider] has asked *[Health Plan]* to approve *[Service requested].* We cannot make a decision yet. This is because *[Insert a clear and concise explanation of the reasons for the delay, indicating what further information is needed and/or additional steps need be taken. If further information is being requested, input the deadline for receipt of information.]* We expect to let you know the decision on *[date]*. You will get another letter letting you know the decision at that time.

You may appeal this decision. 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)