"Deny"

[Health Plan or PPG Letterhead]

[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]*. 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 may ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria that we based our decision on. To ask for this, please call *[Health Plan name]* at *[telephone number]*.

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)