[Health Plan or PPG Letterhead]

"Overturn"

[Health Plan or PPG Tracking Number – optional]

NOTICE OF APPEAL RESOLUTION

[Date]

[Member's Name]
[Address]
[City, State Zip]

[Treating Provider's Name]
[Address]
[City, State Zip]

Identification Number

RE: *[Service requested]*

You or *[Name of requesting provider or authorized representative]*, on your behalf, appealed the *[denial, delay, modification, or termination]* of *[Service requested]. [Health Plan or PPG]* has reviewed the appeal and has decided to overturn the original decision. This request is now approved. 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]*.

[Health Plan or PPG] has 72 hours to give you the service.

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]