[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.

[MCPs that are unable to fully translate during the 6-month compliance period must insert the following:

You will get a translated copy of this letter in your preferred language within 30 days. If you need help understanding this letter please call [Health Plan] at [Telephone Number] to have this letter explained to you over the telephone. If you are speaking or hearing impaired, please use the TTY/TTD number [XXX], between 8:00 a.m. and 6:00 p.m. for help.]

This letter tells you that *[Medical group/IPA name]*, cannot provide the care you asked for (shown above).

You can get the care from *[Entity responsible for carved-out service]*. You can call them at *[telephone number]*. You can also contact *[Health Plan]* and we will help you get the care you need and contact *[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].*

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 us at *[Health Plan's Member Services telephone number]*.

This letter does not change your other Medi-Cal care.

[Medical Director's Name]