[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]*

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

You will get a fully 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.]

[Name of requesting provider] has asked *[Health Plan]* to approve *[Service requested].* We need more time to make a decision. This is because *[Insert a clear and concise explanation of the reasons for the delay, indicating the specific information or whatever additional information the plan needs 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 will send you another letter on *[date]*, to tell you the decision.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

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]

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

(Enclose notice with each letter)