[Health Plan or PPG Letterhead] "Modify"

[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 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 cannot approve this treatment the way it is. 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]*.

We have instead approved: *[Clear and concise explanation of modification of request and service approved].*

You can get free copies of all information used to make this decision. To ask for this, please call *[Health Plan name]* at *[telephone number]*.

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 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 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)