[Health Plan or PPG Letterhead]
[Health Plan or PPG Tracking Number – optional]

"Overturn"

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]*

[*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. For the speaking or hearing impaired, please use TTY/TTD number [XXX], between 8:00 a.m. and 6:00 p.m. for help.]

You or *[Name of requesting provider or authorized representative]* appealed the *[denial, delay, modification, or termination]* of *[Service requested]. [Health Plan or PPG]* 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 name] will authorize or provide the requested service within 72 hours. *[Health Plan name]* has also notified the doctor that requested the service of its decision.

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]