"Deny"

[Dental Plan Letterhead]

[Dental Plan Tracking Number-Optional]

NOTICE OF ACTION
About Your Treatment Request

[Date]

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

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

Identification Number

RE: *[Service requested]*

[Dental plans 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 [Dental 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 [insert service hours] for help.]

[Name of requesting provider] has asked *[Dental Plan]* to approve *[Service requested].* This request is denied. 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].*

You can get free copies of all the information used to make this decision. To ask for this, please call [*Dental 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 can call them at 1-888-452-8609. You can also get help from your dentist, or call us at *[Dental Plan’s Member Services Telephone Number]*.

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

[Dental Director’s Name]

Enclosed: “Your Rights under Dental Managed Care”

(Enclose notice with each letter)