

**NOTICE OF ADVERSE BENEFIT DETERMINATION  
About Your Treatment Request**

Date

Beneficiary's Name  
Address  
City, State Zip

Treating Provider's Name  
Address  
City, State Zip

**RE:** [Service requested]

Our records show that you filed a *grievance or appeal* with the *Plan or (Name of provider)* on *date filed*. Unfortunately, the *Plan* did not finish reviewing the *grievance or appeal* within the required timeline.

We apologize for the delay in processing your *grievance or appeal*. We are working on it and will provide you with a decision as soon as possible.

You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where you can get help with your appeal. This also means free legal help. You are encouraged to send with your appeal any information or documents that could help your appeal. The enclosed "Your Rights" information notice provides timelines you must follow when requesting an appeal.

The Plan can help you with any questions you have about this notice. For help, you may call *Plan hours of operation* at *Plan's Member Services telephone number*. If you have trouble speaking or hearing, please call TTY/TTD number *TTY/TTD number*, between *hours of operation* for help.

If you need this notice and/or other documents from the Plan in an alternative communication format such as large font, Braille, or an electronic format, or, if you would like help reading the material, please contact *Plan* by calling *telephone number*.

If the Plan does not help you to your satisfaction and/or you need additional help, the State Medi-Cal Managed Care Ombudsman Office can help you with any questions. You may call them Monday through Friday, 8am to 5pm PST, excluding holidays, at 1-888-452-8609.

This notice does not affect any of your other Medi-Cal services.

*Signature Block*

Enclosed: "Your Rights"

*Enclose notice with each letter*