# NOTICE OF ADVERSE BENEFIT DETERMINATION

# About Your Treatment Request

#### Date

## *Beneficiary’s Name* *Treating Provider’s Name*

*Address* *Address*

*City, State Zip* *City, State Zip*

### RE: *Your Specialty Mental Health Services*

You are currently receiving *Specialty Mental Health Services from Kings View.* Beginning on *termination date* we will no longer approve this treatment. This is because *our records indicate that your last date of service was over 90 days ago on, date. We have made several attempts to contact you to schedule a follow up and have not been successful. Please call us at phone number or come into the office to schedule an appointment. If we do not hear from you by date (at least 10 days from date on letter), we will presume that you are no longer in need of services and your services will be terminated and your case closed. However, please know that you may come in at anytime during business hours to be reassessed for services.*

You may appeal this decision if you think it is incorrect. 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.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that weused to makeour decision. To ask for this, please call *Patients Rights Advocate* at *559-852-2423*.

If you want to keep getting this service while we decide on your appeal, you must ask for an appeal within 10 days from the date on this letter, or before the date your plan says services will be stopped or reduced, listed above.

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

The Plan can help you with any questions you have about this notice. For help, you may call *Patients Rights Advocate* at *559-852-2423 or email:bhpra@co.kings.ca.us*. If you have trouble speaking or hearing, please call TTY/TTD number*7-1-1*, between 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 *Patients Rights Advocate* by calling *559-852-2423*.

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.

*Signature Block*

Enclosed: “Your Rights”

*Enclose notice with each letter*