# 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: *Specialty Mental Health Services*

This notice lets you know that *Kings County Mental Health Plan* has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services. This is because (mark only one of the following):

* *Your mental health diagnosis identified in the assessment is not considered an included diagnosis by Medi-Cal [9 CCR, Section 1830.205(b)(1)].*
* *Your mental health condition does not cause severe impairment(s) in significant areas of your life, demonstrate a present risk of deterioration in significant areas of life, or indicate an inability to meet developmental milestones [9 CCR, Section 1830.205 (b)(2)].*
* *Specialty Mental Health Services provided are not likely to help you reduce impairment, or risk of deterioration, in significant areas of life that are caused by your mental health condition [9 CCR, Section 1830.205(b)(3)(A) and (B)].*
* *Your mental health condition would be responsive to treatment by a physical health care provider [9 CCR, Section 1830.205(b)(3)(C)].*

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from name of provider. You can call them at *telephone number and/or your appointment was set for: Appointment.*

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 *the Patients Rights Advocate* at *559-852-2423.*

If you are currently getting services and you want to keep getting services 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 mental health plan says services will be stopped or reduced.

The Plan can help you with any questions you have about this notice. For help, you may call *the Patient 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* 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.

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

*Signature Block*

Enclosed: “Your Rights”

*Enclose notice with each letter*