NOTICE OF ACTION
DENIAL
About Your Treatment Request

DATE, 2015

MEMBER NAME
ADDRESS 1
ADDRESS 2

Referral Provider
Address 1
Address 2

CenCal ID #:
CenCal Auth #:

Dear MEMBER NAME,

Denial verbiage

If you do not understand the above paragraph, please call Member Services toll-free at 1-877-814-1861.

These are the rules we use in deciding whether you need the requested treatment or not. You have a right to see these rules and our Member Services Department will be happy to get copies for you if you call us toll free at 1-877-814-1861 and ask for copies.

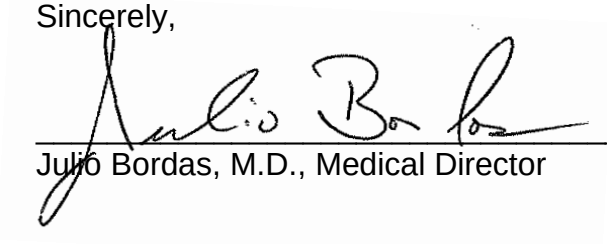
You may appeal this decision. The enclosed "Your Rights" information notice tells you how. It also tells you where to go to get help, including free legal help.

The State Medi-Cal Managed Care "Ombudsman Office" is available to answer questions and help you with this notice. You may call them at 1-888-452-8609. You may also get help from your doctor, or call the CenCal Health Member Services Department toll free at **1-877-814-1861.** If you would like to send your appeal request in writing, visit www.CenCalHealth.org, or call 1-877-814-1861 to request a Complaint/Appeal form. You can also write to:

CenCal Health
Member Services Department
Attention: TAR Appeals
4050 Calle Real, Santa Barbara, CA 93110

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

Sincerely,



Julio Bordas, M.D., Medical Director

7/29/15
Date

cc: PCP, Facility, fax # (DOB of member)

Appeal of a Treatment Authorization Request (TAR)

If provider receives a letter of denial, deferral, or modification of a TAR, the provider may contact the physician reviewer or licensed health care professional or file an appeal by calling or writing to the address and/or telephone number listed below:

CenCal Health
Health Services Department
4050 Calle Real
Santa Barbara, CA 93110
(805) 562-1646

Dr. Bordas' Direct Line: (805) 562-1019

APPEAL PROCESS:

Providers may appeal denied or modified TARs by submitting the following documentation within 90 calendar days from the date of the original decision:

- A copy of the original TAR and denial notification
- A letter stating why denial or modification should be overturned
- Documentation to support overturning the original denial or modification

Providers are notified of receipt of their appeals and the appeals process within five working days.

The provider will receive a written response within thirty (30) calendar days of receipt regarding the determination of the appeal. If a decision cannot be reached within 30 working days, notice will be provided to the provider of the reason for the delay and a written decision will be issued within fifteen (15) additional days.

The appeal will be reviewed by the Medical Director/Associate Medical Director or his/her physician designee, who may reverse the decision.

1-877-814-1861 (Toll-Free)
8:00 a.m. to 5:00 p.m.
Monday through Friday

For the Hearing Impaired:1-800-735-2929 or call the Toll-Free number and dial 711

EXPEDITED APPEALS

When the member's condition is such that the member faces an imminent and serious threat to his or her health including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decision making process would be detrimental to the member's life, health, or could jeopardize the member's ability to regain maximum function, an expedited review may be requested by calling a Member Services Representative at the phone number listed below. If the appeal meets the criteria for an expedited review a decision shall be made in a timely fashion not to exceed 72 hours after CenCal Health's receipt of information necessary and required to make the determination. Expedited appeals may be initiated by the member or by the provider acting on behalf of the member. Expedited appeals are performed by CenCal Health only when, in the judgment of CenCal Health, a delay in decision making might seriously jeopardize the life or health of the member. If your appeal does not meet the criteria for an expedited review, we will send you a letter within five (5) calendar days telling you we have received your appeal and it will be resolved within thirty (30) calendar days.

The provider will be notified in writing of the expedited appeal within 24 hours of the decision. Written confirmation of the decision will be provided within two (2) working days if the initial decision was not in writing.

If the service has not been provided, Members are informed of their right to file an appeal. For additional information or assistance, Members may contact the CenCal Health Member Services Department at:

CenCal Health
Member Services Department
Attention: TAR APPEALS
4050 Calle Real, Santa Barbara, CA 93110

YOUR RIGHTS
UNDER MEDI-CAL MANAGED CARE

If you do not agree with this decision you may
- Ask for a "State Hearing"
- File a grievance with your health plan

You can file a grievance with your health plan **and** ask for a State Hearing at the same time.

You will not have to pay for either of these.

STATE HEARINGS

You may ask for a State Hearing in writing. Fill out the enclosed form or send a letter to:

California Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 9-17-37
Sacramento, California 94244-2430

Alternatively, you may call **1-800-952-5253** to ask for a State Hearing. This number can be very busy so you may get a message to call back later. If you have trouble hearing or speaking, you can call **TDD 1-800-952-8349**.

If you want a State Hearing, you must ask for it within 90 days from the date of this letter, **UNLESS you and your primary care physician want to keep the treatment going** that this Notice of Action is stopping or reducing. **Then, you must ask for a State Hearing within 10 days from the date this letter was postmarked or personally delivered to you or before the effective date of the action which you are disputing.** Please state that you want to keep getting your treatment during the hearing process.

If you use the enclosed form or write a letter to ask for a State Hearing, be sure to include your name, address, phone number, Social Security Number, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address and phone number to the form or letter. If you need a free interpreter, tell us what language you speak.

LEGAL HELP

You may speak for yourself at the State Hearing or have someone else speak for you, including a relative, friend or attorney. You must get the other person yourself.

You may be able to get free legal help by calling contacting the following:

Santa Barbara	Santa Maria	San Luis Obispo
Office of the District Attorney 1105 Santa Barbara Street Santa Barbara, CA 93101 (805) 568-2437	Office of the District Attorney 312-D East Cook Street Santa Maria, CA 93454 (805) 346-7632	Office of the District Attorney County Government Center, 4th Floor San Luis Obispo, CA 93408 (805) 781-5800

- Legal Aid Foundation of Santa Barbara County

301 E. Cañon Perdido St. Santa Barbara, CA 93101	301 S. Miller St., Suite 116 Santa Maria, CA 93454	106 S. C St., Suite A Lompoc, CA 93436
(805) 963-6754 (phone) (805) 963-6756 (fax)	(805) 922-9909 (phone) (805) 347-4494 (fax)	(805) 736-6582 (phone) (805) 347-4494 (fax)

- California Rural Legal Assistance, Inc.

Santa Barbara: (805) 963-5981	Santa Maria: (805) 922-4563
Paso Robles: (805) 239-3708	San Luis Obispo (805) 544-7997

GRIEVANCES

You may ask for a grievance by calling CenCal Health at 1-877-814-1861 (toll free), by filing it through www.cencalhealth.org, or by sending your grievance to:

CenCal Health
Member Services Department
4050 Calle Real
Santa Barbara, CA 93110

Your doctor will have grievance forms. CenCal Health will review its decision based on your grievance and you will get an answer within 30 days. If you think that waiting 30 days will harm your health, be sure to say why when you ask for your grievance. Then you might be able to get an answer within 3 calendar days.

OTHER INFORMATION

CenCal Health wants to try to help you with your problem so we hope you will call us first.

FORM TO FILE A STATE HEARING

You can ask for a State Hearing by calling: 1-800-952-5253:
TDD users, call 1-800-952-8349.
Or you can fill out this form and FAX it to State Hearing Support at:
(916) 651-2727

Or you can mail this page to:
California Department of Social Services
State Hearings Division
P.O. Box 944243
Mail Station 9-17-37
Sacramento, California 94244-2430

For free help filling out this form, call the legal help phone number listed on "Your Rights."

I do not agree with the decision about my health care. Here's why:

_____

_____

_____

(If you need more space, use another piece of paper. Make a copy for your records.)

Check these boxes only if they apply to you:

(1) ❑ I want the person named below to represent me. She/he can see my medical records that relate to this hearing, come to this hearing, and speak for me.
Name: _____
Address: _____ Phone number: _____

(2) ❑ I need a free interpreter. My language or dialect is: _____

(3) ❑ I also want to file a grievance against the health plan. I understand the State will send my health plan a copy of this form.

(4) ❑ My situation is **urgent**. I need a quick decision and cannot wait 90 days because:

(Explain what may happen without a quick decision. As discussed in the "Your Rights" information notice, you will also need a letter from your doctor or health plan if you want an expedited hearing).

(5) ❑ Please continue the service my Plan has stopped until my hearing.

My Name: _____
My Social Security Number: _____ Phone Number: _____
Address: _____
_____

My signature: _____ Today's Date: _____

(After you complete this form, make a copy for your records)