**NOTICE OF ADVERSE BENEFIT DETERMINATION**

**About Your Treatment Request**

#### DELIVERY SYSTEM NOTICE

#### Date

|  |  |  |
| --- | --- | --- |
| *Beneficiary’s Name* |  | *Treating Provider’s Name* |
| *Address* |  | *Address* |
| *City, State Zip* |  | *City, State Zip* |

### RE: *Service requested*

This notice lets you know that*the San Bernardino County Department of Behavioral Health (DBH, also referred to as the Plan throughout this document)* has determined that your mental health condition does not meet the medical necessity criteria to be eligible for specialty mental health services.

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| *1. Using plain language, insert a description of the criteria or guidelines used, including a citation to the specific regulations and plan authorization procedures that support the action; and* |
| *2. The clinical reasons for the decision regarding medical necessity* |

Although you do not qualify for specialty mental health services, you may be able to receive non-specialty mental health services from *Health Plan or Entity responsible for mental health services, e.g., physical health care provider*. You can call them at *telephone number.*

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 *Clinic* at *Clinic Phone Number,* OR

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| [ ]  | *The DBH Access Unit at 1 (888) 743-1478* |
| [ ]  | *Substance Use Disorder and Recovery Services (SUDRS) at 1 (800) 968-2636* |
| *24 hours a day, 7days a week*. |

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 ten (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 DBH Access Unit* *24 hours a day, 7 days a week* at *1 (888) 743-1478*. If you have trouble speaking or hearing, please call the TTY/TTD number *7-1-1*, *24 hours a day, 7 days a week* 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 *the DBH Access Unit* by calling *1 (888) 743-1478*.

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, 8 a.m. to 5 p.m. PST, excluding holidays, at 1 (888) 452-8609.

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

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| Authorized Printed Name | Authorized Signature |

Enclosed: ["Your Rights" (NOABD)](http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/06/9.-Your-Rights-Attachment-NOABD-QM024_E.docx)

 [Language Assistance Taglines](http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/06/14.-DBH-Language-Assistance-QM027_E.docx)

 [Beneficiary Nondiscrimination Notice](http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/06/13.Beneficiary-Nondiscrimination-Notice-QM026_E.docx)