# NOTICE OF ADVERSE BENEFIT DETERMINATION

# About Your Treatment Request

**DENIAL NOTICE**

#### Date

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

### RE: *Service requested*

*Name of requestor* has asked *the San Bernardino County Department of Behavioral Health (DBH, also referred to as the Plan throughout this document)* to approve *Service requested.*

This request is denied. The reason for the denial is:

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| *1. Using plain language, insert a clear and concise explanation of the reasons for the decision;* |
| *2. A description of the criteria or guidelines used,* |
| *including a citation to the specific regulations and authorization procedures that support the action, and* |
| *3. The clinical reasons for the decision regarding medical necessity.* |

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 *the 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 |

Enclosures: ["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)