Medi-Cal Specialty Mental Health Program
NOTICE OF ACTION - C
(Post-Service Denial of Payment)

Date: _____

To: _____ , Medi-Cal Number _____

The Mental Health Plan for **Riverside County** has ☐ denied ☐ changed your provider's request for payment of the following service(s): _____

The request was made by: (provider name) _____

The original request from your provider was dated _____ and your provider says that you

received the service on the following dates: _____

THIS IS NOT A BILL. YOU WILL NOT HAVE TO PAY FOR THE SERVICE OR SERVICES DESCRIBED ON THIS FORM.

The Mental Health Plan took this action based on information from your provider for the reason checked below:

☐ Your mental health condition does not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205

☐ Your mental health condition does not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____

_____

☐ The service requested is not covered by the Mental Health Plan (Title 9, CCR, Section 1810.345).

☐ The Mental Health Plan requested additional information from your provider that the plan needs to approve payment of the proposed service. To date, the information has not been received.

☐ The Mental Health Plan will pay for the following service(s) instead of the service requested by your provider, based on the available information on your mental health condition and service needs: _____

_____

☐ Other _____

_____

If you don't agree with the plan's decision, you may do one or more of the following:

1. You may file an appeal with your Mental Health Plan. To do this, you may call and talk to a representative of your Mental Health Plan at (951) 358-6654 or write to Inpatient Quality Improvement, Attn: Appeals , P.O. Box 7549, Riverside, CA 92513 or follow the directions in the information brochure the Mental Health Plan has given you. You must file an appeal within 90 days of the date of this notice.

2. If you are unhappy with the outcome of your appeal, you may request a state hearing. The other side of this notice explains how to request a hearing. The state hearing will decide if the plan should pay your provider for the service that you already received. Whatever the appeal or state hearing decision, you will not have to pay for the service.

YOUR HEARING RIGHTS

You only have 90 days to ask for a hearing. The 90 days start either:

1. The day after we personally gave you this the mental health plan's appeal decision notice, OR
2. The day after the postmark date of this mental health plan's appeal decision notice.

Expedited State Hearings

It usually takes about 90 days from the date of your request to make a hearing decision. If you think this timing will cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions, you may request an expedited state hearing. **To request an expedited hearing, please check the 1st box in the right hand column of this page under HEARING REQUEST and include the reason why you are requesting an expedited hearing.** If your expedited hearing request is approved, a hearing decision will be issued within three working days of the date your request is received by the State Hearings Division.

To Keep Your Same Services While You Wait for A Hearing

- You must ask for a hearing within 10 days from the date the mental health plan's appeal decision notice was mailed or personally given to you or before the effective date of the change in services, whichever is later.
- Your Medi-Cal mental health services will stay the same until a final hearing decision is made which is adverse to you, you withdraw your request for a hearing, or the time period or service limits for your current services expire, whichever happens first.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

To Get Help

You may get free legal help at your local legal aid office or other groups. You can ask about your hearing rights or free legal aid from the Public Inquiry and Response Unit:

Call toll free:	1-800-952-5253
If you are deaf and use TDD, call:	1-800-952-8349

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, an attorney or anyone else you choose. You must arrange for this representative yourself.

Information Practices Act Notice (California Civil Code Section 1798, et. seq.) The information you are asked to write in on this form is needed to process your hearing request. Processing may be delayed if the information is not complete. A case file will be set up by the State Hearings Division of the Department of Social Services. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown above). Any information you provide may be shared with the mental health plan, the State Departments of Health Services and Mental Health and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2)

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page. Make a copy of the front and back for your records. Then send this page to:

State Hearings Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-37
Sacramento, CA 94244-2430

Another way to ask for a hearing is to call 1-800-952-5253. If you are deaf and use TDD, call 1-800-952-8349.

HEARING REQUEST

I want a hearing because of a Medi-Cal related action by the Mental Health Plan of _____ County.

☐ Check here if you want an expedited state hearing and include the reason below.

Here's why: _____

_____

_____

_____

_____

_____

_____

_____

☐ Check here and add a page if you need more space.

My name: (print) _____

My Social Security Number: _____

My Address:(print) _____

_____

My phone number: (_____)_____

My signature: _____

Date: _____

I need an interpreter at no cost to me. My language or dialect is: _____

I want the person named below to represent me at this hearing. I give my permission for this person to see my records and to come to the hearing for me.

Name _____

Address _____

_____

Phone number: _____