EXAMPLE

NOTICE OF ADVERSE BENEFIT DETERMINATION
About Your Treatment Request

August 15, 2026

Mary Ann Jones
567 8th Street
Los Angeles, CA 90034

John Smith, Ph. D.
123 4th Street
Los Angeles, CA 90012

RE: ***Psychological Testing***

John Smith, Ph.D., has asked the *LACDMH network provider*, *Jane Doe, Ph D*. to approve psychological testing. This request is denied. The reason for the denial is the request for psychological testing was made to determine if medication is needed. The criteria used for the determination can be found in *the County of Los Angeles, Department of Mental health, Local Mental Health Plan, Medi-Cal Specialty Mental Health Services, Fee-For-Service Network Provider Manual 10th Edition, August 2026. The Clinical reasons for the decision regarding medical necessity is that the beneficiary should be referred to a psychiatrist to support medication evaluation and management.*

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 we used to make our decision. To ask for this, please call *LACDMH Jane Doe, Ph.D.* at *(123) 456-7890*.

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 the LACDMH network provider, Jane Doe, Ph.D, 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 *Intensive Care Division, Central Authorization Unit 8:00 am to 5:00 pm* at *(213) 738-4889*. If you have trouble speaking or hearing, please call TTY/TTD number *(213) 738-4888*, between *8:00 am to 5:00 pm* 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 *DMH ACCESS Center* by calling *(800) 854-7771*.

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.

Jane Doe, Ph.D.
Network Psychologist

Enclosures: "Your Rights"
Language Assistance Taglines
Beneficiary Non-Discrimination Notice

Enclose notice with each letter

ENCLOSURE "YOUR RIGHTS"

For Mental Health Plans and DMC-ODS County Plans

YOUR RIGHTS UNDER MEDI-CAL

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 ACCESS Center by calling (800) 854-7771.

If you still do not agree with the plan's decision, you can ask for a **"State Hearing"** and a judge will review your case.

You must ask for a State Hearing within **120 days** from the date of this letter. However, **if you are currently getting treatment and you want to continue your treatment while you appeal, you must ask for a State Hearing within 10 days** from the date this letter was postmarked or delivered to you OR before the date your health plan says services will be stopped or reduced. When you ask for a State Hearing, you must say that you want to keep getting your treatment. You will not have to pay for a State Hearing.

You can ask for a State Hearing by phone, electronically, or in writing:

- By phone: Call **1-800-952-5253**. If you cannot speak or hear well, please call **TTY/TDD 1-800-952-8349**.
- Electronically: You may request a State Hearing online. Please visit the California Department of Social Services' website to complete the electronic form: https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx
- In writing: Fill out a State Hearing form or send a letter to:

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

  Be sure to include your name, address, telephone number, Date of Birth, and the reason you want a State Hearing. If someone is helping you ask for a State Hearing, add their name, address, and telephone number to the form or letter. If you need an interpreter, tell us what language you speak. You will not have to pay for an interpreter. We will get you one.

After you ask for a State Hearing, it could take up to 90 days to decide your case and send you an answer. If you think waiting that long will harm your health, you might be able to get an answer within 72 hours. You may wish to ask your doctor or mental health plan to write a letter for you or you may write your own. The letter must explain

in detail how waiting for up to 90 days for your case to be decided will seriously harm your life, your health, or your ability to attain, maintain, or regain maximum function. Then, make sure you ask for an "**expedited hearing,**" and provide the letter with your request for a hearing.

Authorized Representative

You may speak for yourself at the State Hearing or have another person speak for you, such as a relative, friend, advocate, doctor, or attorney. If you want another person to speak for you, then you must tell the State Hearing office that the person is allowed to speak on your behalf. This person is called an "authorized representative."

Legal Help

You may be able to get free legal help. You may call the local Legal Aid program in your county at 888-804-3536.

ENCLOSURE 'LANGUAGE ASSISTANCE TAGLINES'

Send with all notices

LANGUAGE ASSISTANCE

English
ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call (800) 854-7771) (TTY: (213)738-4888).

ATTENTION: Auxiliary aids and services, including but not limited to large print documents and alternative formats, are available to you free of charge upon request. Call (800) 854-7771). (TTY: (800)854-7771).

Español (Spanish)
ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 854-7771). (TTY: (800) 854-7771).

Tiếng Việt (Vietnamese)
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 854-7771). (TTY: (800) 854-7771).

Tagalog (Tagalog – Filipino)
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 854-7771
(TTY: (800) 854-7771).

한국어 (Korean)
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
(800) 854-7771 (TTY: (800) 854-7771)번으로 전화해 주십시오.

繁體中文(Chinese)
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 854-7771
(TTY: (800) 854-7771)。

Send with all notices

Հայերեն (Armenian)
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (800) 854-7771 (TTY (հեռատիպ)՝ (800) 854-7771):

Русский (Russian)
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 854-7771). (телетайп: (800) 854-7771).

فارسی (Farsi)
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با ((800) 854-7771). (TTY: (800) 854-7771 تماس بگیرید.

日本語 (Japanese)
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。
(800) 854-7771 (TTY: (800) 854-7771) まで、お電話にてご連絡ください。

Hmoob (Hmong)
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 854-7771 (TTY: (800) 854-7771).

ਪੰਜਾਬੀ (Punjabi)
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
(800) 854-7771 (TTY: (800) 854-7771) ਤੇ ਕਾਲ ਕਰੋ।

العربية (Arabic)
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 854-7771 (رقم هاتف الصم والبكم: 854-7771 (800)).

हिंदी (Hindi)
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
(800) 854-7771 (TTY: (800) 854-7771) पर कॉल करें।

ภาษาไทย (Thai)
เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 854-7771 (TTY: (800) 854-7771).

Send with all notices

ខ្មែរ (Cambodian)
ប្រយ័ត្ន៖ រ សើ ិនជាអ្នកនិយាយ ភាសាខ្មែ , រសវាជំនួយមននកភាសា ោយមិនគិតឆ្ន ន
គឺអាចមានសវ ំរ អ្ន ិនក ចូ ទូ សព្ទ (800) 854-7771 (TTY: (800) 854-7771)។

ພາສາລາວ (Lao)
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍ່ວິການຊ່ວຍເຫຼືອດ້ານພາສາ,
ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 854-7771 (TTY: (800) 854-7771).

ENCLOSURE 'BENEFICIARY NON-DISCRIMINATION NOTICE'

NONDISCRIMINATION NOTICE

Discrimination is against the law. Los Angeles County Department of Mental Health (LMHP) follows Federal civil rights laws. LMHP does not discriminate, exclude people, or treat them differently because of race, color, national origin, age, disability, or sex.

LMHP provides:

- Free aids and services to people with disabilities to help them communicate better, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact ACCESS Center 24 hours a day, 7 days a week by calling (800) 854-7771: Or, if you cannot hear or speak well, please call (800) 854-7771.

Send with all notices

HOW TO FILE A GRIEVANCE

If you believe that LMHP has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with LMHP Patient's Rights. You can file a grievance by phone, in writing, in person, or electronically:

- By phone: Contact Patient's Rights between 8:00 am through 5:00 p.m. by calling (213)738-4888 or (800) 700-9996. Or, if you cannot hear or speak well, please call ACCESS Center at (800) 854-7771.

- In writing: Fill out a grievance form, or write a letter and send it to:

  Los Angeles County, Department of Mental Health, Patients' Rights Office
  550 South Vermont Avenue, Los Angeles, CA 90020

- In person: Visit Los Angeles County, Department of Mental Health, Patients' Rights Office 550 South Vermont Avenue, Los Angeles, CA 90020 and say you want to file a grievance.

OFFICE OF CIVIL RIGHTS

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights by phone, in writing, or electronically:

- By phone: Call **1-800-368-1019**. If you cannot speak or hear well, please call **TTY/TDD 1-800-537-7697**.

- In writing: Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

- Electronically: Visit the Office for Civil Rights Complaint Portal at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf.