#### ADVERSE BENEFIT DETERMINATION UPHELD

#### Date

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

### RE: *Service requested*

You or*Name of requesting provider or authorized representative*,on your behalf, appealed the *denial, delay, modification, reduction or termination or other adverse benefits determination* of *Service requested.* *The San Bernardino County Department of Behavioral Health (DBH, also referred to as the Plan throughout this document)*has reviewed the appeal and has decided to uphold the decision. This request is still denied. This is because:

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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 ask for free copies of all information used to make this decision. This includes a copy of the actual benefit provision, guideline, protocol, or criteria on which we based our 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*. | |

You may appeal this decision by requesting a State Hearing. 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 in any information that could help your case. The enclosed “Your Rights” information notice provides timelines you must follow when requesting an appeal.

*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.

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| Authorized Printed Name | Authorized Signature |

Enclosed: ["Your Rights" (NAR)](http://wp.sbcounty.gov/dbh/wp-content/uploads/2019/06/11.-Your-Rights-Attachment-NAR-QM025_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)