**NOTICE OF ADVERSE BENEFIT DETERMINATION**

**About Your Treatment Request**

**GRIEVANCE AND APPEAL TIMELY RESOLUTION NOTICE**

#### Date

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

### RE: *Service requested*

Our records show that you filed a *grievance or appeal* with *the San Bernardino County Department of Behavioral Health (DBH, also referred to as the Plan throughout this document)* on *date filed.* Unfortunately, *DBH* did not finish reviewing the *grievance or appeal* within the required timeline.

We apologize for the delay in processing your *grievance or appeal*. We are working on it and will provide youwith a decision assoon as possible.

You may appeal this decision. 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.

*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.

|  |  |
| --- | --- |
| *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)