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NOTICE OF APPEAL RESOLUTION

Date

Member's Name
Address
City, State Zip

Treating Provider's Name
Address
City, State Zip

RE: *Service requested*

You or *Name of requesting provider or authorized representative*, on your behalf, appealed the *denial, delay, modification, or termination* of *Service requested*. Contra Costa DMC-ODS Plan has reviewed the appeal and has decided to overturn the original decision. This request is now approved. This is because *Using plain language, insert: 1. A clear and concise explanation of the reasons for the decision; 2. A description of the criteria or guidelines used, including a reference to the specific regulations or plan authorization procedures that support the action; and 3. The clinical reasons for the decision regarding medical necessity.*

Plan or Provider is required to authorize or provide you with the service within 72 hours.

The Plan can help you with any questions you have about this notice. For help, you may call Contra Costa DMC-ODS Plan 8:00 AM to 5:00 PM at 1-800-846-1652. If you have trouble speaking or hearing, please call TTY/TTD number 800 735 2922 between 8:00 AM to 5:00 PM M-F 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 Contra Costa DMC-ODS Plan by calling 1-800-846-1652.

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.

Signature Block