<IPA LOGO>

NOTICE OF ACTION
About Your Treatment Request

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

<<Treating Provider's Name>>
<<Address>>
<<City,>> <<State>> <<Zip>>

Identification Number: <<Member ID Number>>; Case #: <<Insert case number>>

RE: <<Service Requested>>

[Name of requesting provider] has asked <IPA> to approve *[Service requested]*. We need more time to make a decision. This is because *[Insert a clear and concise explanation of the reasons for the delay, indicating the specific information or whatever additional information the plan needs what further information is needed and/or additional steps need be taken. If further information is being requested, input the deadline for receipt of information.]* We will send you another letter on *[date]*, to tell you the decision.

You can appeal this decision. The enclosed "Your Rights" information letter tells you how. It also tells you how you can get free help. This can be free legal help. You can send in any information that could help your case. The "Your Rights" letter tells you the last day you can ask for an appeal.

The State Medi-Cal Managed Care "Ombudsman Office" can help you with any questions. You can call them at 1-888-452-8609. You can also get help from your doctor or call us at **1-800-440-IEHP (4347).**

This letter does not change your other Medi-Cal care.

[Medical Director's Name]

Enclosed: "Your Rights under Medi-Cal Managed Care"