**“ABD Overturned”**

**NOTICE OF APPEAL RESOLUTION**

*Date*

*Member’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, or termination* of *Service requested*. San Mateo County Behavioral Health and Recovery Services (BHRS) 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.*

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

The Quality Management Department can help you with any questions you have about this notice. For help, you may call Quality Management Monday through Friday, 8am to 5pm PST, at (650) 573-3431. If you have trouble speaking or hearing, please call 711 or the California Relay Service at (800) 855-7100, available 24 hours a day, 7 days a week for help.

If you need this notice and/or other documents from BHRS 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 BHRS by calling (800) 388-5189.

If BHRS 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*