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| Text  AI-generated content may be incorrect. | **NOTICE OF**  **ADVERSE BENEFIT DETERMINATION**  FINANCIAL LIABILITY |

# NOTICE OF ADVERSE BENEFIT DETERMINATION

# About Your Financial Liability

Date

|  |  |
| --- | --- |
| Member's Name | Treating Provider's Name |
| Address | Address |
| City, State, Zip | City, State, Zip |
| Medi-Cal Number | Telephone Number |

### RE: Service Requested

San Francisco Behavioral Health Services has denied your dispute of financial liability regarding insert a description of the disputed financial liability (e.g., cost-sharing, co-insurance, other liabilities). This is because Using plain language, insert a clear and concise explanation of the reasons for the denial. If further information is need, indicate what further information is needed and/or additional steps need be taken, if necessary.

You may appeal this decision if you think it is incorrect. 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.

You may ask for free copies of all information used to make this decision. This includes a copy of the guideline, protocol, or criteria that weused to makeour decision. To ask for this, please callthe provider at the above telephone number.

The Plan can help you with any questions you have about this notice. For help, you may call between 8am – 5pm, Monday through Friday, at 1-888-246-3333. If you have trouble speaking or hearing, please call TDD number 711, between 8am – 5pm, Monday through Friday, 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 Behavioral Health Access Center by calling 1-888-246-3333.

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.

This notice does not affect any of your other Medi-Cal services.

Enclosures: NOABD “Your Rights”

Notice of Availability

Nondiscrimination Notice

cc: Quality Management