SANTA BARBARA COUNTY DEPARTMENT OF Behavioral Wellness
A System of Care and Recovery

Date: _____

Medi-Cal Specialty Mental Health Services Program
NOTICE OF ACTION (C)
(Post-Service Denial of Payment)

To:_____Medi-Cal Number _____

The mental health plan for Santa Barbara County has ❑ denied ❑ changed your provider's request for payment of the following service(s):

The request was made by: (provider name) _____

The original request from your provider was dated_____and your provider says that you received the services on the following date(s): _____

You do not need to pay for these services.

This does not change the services you will receive in the future.

The mental health plan took this action based on information from your provider for the reason checked below:

- ❑ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for psychiatric inpatient hospital services or related professional services (Title 9, California Code of Regulations (CCR), Section 1820.205).
- ❑ Your mental health condition as described to us by your provider did not meet the medical necessity criteria for specialty mental health services other than psychiatric inpatient hospital services for the following reason (Title 9, CCR, Section 1830.205): _____
- ❑ The service requested is not covered by the mental health plan (Title 9, CCR, Section 1810.345).
- ❑ The mental health plan requested additional information from your provider that the plan needs to approve payment of the services you received. To date, the information has not been received.
- ❑ Other: _____

If you don't agree with the plan's decision, you may do one or more of the following by calling or writing a representative at the address below:

1. You may file an appeal with your mental health plan.

You must file an appeal within 60 days of the date of this notice. In most cases the mental health plan must make a decision on your appeal within 30 days of your request. You may request an expedited appeal, which must be decided within 72 hours, if you believe that a delay would cause serious problems with your mental health, including problems with your ability to gain, maintain or regain important life functions.

2. If you are dissatisfied with the outcome of your appeal, you may request a state hearing. The attached form will explain how to request a hearing.

If you have questions about this notice, you may call and talk to a representative of your mental health plan at (805) 681-4777 or write to: Santa Barbara County Department of Behavioral Wellness - Quality Care Management, 5385 Hollister Ave. Bldg. #14, Box 102 Santa Barbara, CA 93111.