

# NOTICE OF ACTION

You can get this document in a larger print size or in a different format.  
You can also get this document in some languages other than English.  
Contact the person listed on page 2 to ask for this.

Date

Member Name:  
Oregon Health Plan ID:  
Provider Name:  
Date/s of Service:

Name of Member/Member Representative

Address

City, State Zip

Dear Member/Member Representative:

This letter is about your Oregon Health Plan mental health services. It has been sent by Name of LMHA or Agency. We manage these services on behalf of your OHP mental health plan, Mid-Valley Behavioral Care Network (MVBCN).

This is a Notice that your type of mental health service will be reduced or suspended or terminated on effective date of Action. This type of treatment will be reduced or suspended or terminated because reason.

The rule that we are following to make this decision is in the Oregon Administrative Rules at OAR Citation. We are also following the Oregon Department of Human Services contract that applies to your OHP mental health services.

**Oregon Health Plan (OHP) rules say that Provider Name cannot bill you for these services, unless the services are not covered by OHP and you agreed in advance to pay for them.**

If you disagree with this decision and you want to do something about it, you can do one or both of the following:

- **FILE AN APPEAL.** You can file an Appeal to have your mental health plan, MVBCN, review the denial decision. To do this, you must file an Appeal with MVBCN *within 45 calendar days from the date of this Notice*. If you have an urgent problem, you can request an Expedited Appeal.

Information about how to file an Appeal is in the attached document "How to File an Appeal". The form to file an Appeal is also attached.

- **REQUEST A HEARING.** You can request a Hearing with the Addictions and Mental Health Division of the Oregon Department of Human Services. You have two options for requesting a Hearing:
  1. **You can request a Hearing after you have received a decision from MVBCN about your Appeal.** If you do this, you must request a Hearing *within 45 calendar days from the date of the Appeal decision; or*
  2. **You can request a Hearing instead of filing an Appeal.** If you choose this, you must request a Hearing *within 45 calendar days from the date of this Notice.*

Information about how to request a Hearing is in the attached document "Notice of Hearing Rights". The form to request a Hearing is also attached.

**IMPORTANT**

If you want your type of mental health service to stay the same while you wait for the Appeal or Hearing decision, you must file your Appeal or request a Hearing by *effective date of Action* or within 10 calendar days from the date this Notice is mailed or given to you, whichever is later. You need to say on your Appeal form or Hearing request form that you want your services to stay the same. If your services stay the same and you lose the Appeal or Hearing, you may be required to pay for the cost of the services you received from the effective date of Action until the date the Appeal or Hearing decision was made.

If you have questions about this Notice, you can call LMHA, Agency or MVBCN Representative at Phone Number.

If you wish to file an Appeal, follow the instructions in the document called "How to File an Appeal"

Sincerely,

Name and Credentials  
Name of LMHA or Agency or MVBCN  
Address  
City, State Zip

Cc: Provider Name  
MVBCN  
File

Enclosures (for Member only):

1. How to File an Appeal
2. Appeal Form
3. Notice of Hearing Rights (DMAP 3030)
4. DHS Administrative Hearing Request (DHS 0443)