

LMHA or MVBCN letterhead

## 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 of Notice:  
Effective 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 LMHA. We manage these services on behalf of your OHP mental health plan, Mid-Valley Behavioral Care Network (MVBCN).*

- or -

*This letter is about your Oregon Health Plan mental health services. It has been sent by your OHP mental health plan, Mid-Valley Behavioral Care Network (MVBCN).*

MVBCN or LMHA works with mental health care providers to make sure you get the services you can receive under your OHP benefit package. Please know that your OHP mental health benefit package, and other factors, may limit what services and supplies are covered.

On Date we received a request from Requestor's Name for services for the OHP Member listed above. After careful review, we are not able to approve the request because:

- The requested treatment or service/s is not covered by OHP.
- The requested treatment or service/s is not related to a mental health condition.
- The requested treatment or service/s is more than what is necessary for the person's medical needs.
- The requested treatment or service/s requires pre-authorization, and it was not pre-authorized.
- The request is to pay for treatment or service/s not covered by the pre-authorization.
- The request is to pay for treatment or service/s provided outside of the date range covered by the pre-authorization.
- The request is to pay for authorized treatment or service/s; however, it was sent too late to be paid. Payment requests must be sent within 4 months of when the service/s was provided, with some exceptions. The reason for the late request is not one of the allowed exceptions.
- The service/s was provided in an emergency care setting and does not qualify as an Emergency Service.
- The person is not covered by OHP on the date/s of service.
- MVBCN is not the person's OHP mental health plan on the date/s of service. The person has a different OHP mental health plan.

- The person's mental health services are not managed by **LMHA Name** on the date/s of service. A different MVBCN county manages the person's services.
- Other: \_\_\_\_\_

The rule that we are following to make this decision is Oregon Administrative Rule **OAR #**.

**OHP rules say the provider of the services cannot bill you, unless the services are not covered by OHP and you agreed in advance to pay for them.**

If you do not agree with this notice 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 or an Expedited Appeal is in the attached document "How to File an Appeal". The form used 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. To request a Hearing you can:
  1. **Request a Hearing after you have 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. **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.

If you have questions about this Notice, you can call **MVBCN or LMHA 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**  
**MVBCN or LMHA**  
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)

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