

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:
Recipient ID:
Practitioner Name:
Date/s of Service: [or identify in body of Notice]

[Name of Member/Member Rep]
[Mailing Address]
[City, State, Zip]

Dear [Name of Member/Member Rep]:

This is a Notice that the request by [name of requestor] for [type of mental health service] has been denied. This request has been denied because [reason].

The rule that we are following to make this decision is in the Oregon Administrative Rules at [citation]. The text of the OAR is attached to this letter with the relevant section in bold type. [Add additional justification / explanation if necessary, such as MVBCN or Participating Provider policy reference.]

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 have 2 options for filing an Appeal: [For Notice issued by MVBCN, change to reflect 1 option for filing Appeal.]
 1. You can file an Appeal to have us review our decision to deny this request; **or**
 2. You can file an Appeal with your mental health plan, Mid-Valley Behavioral Care Network (MVBCN), to have them review our decision to deny this request.

For either option, you must file your Appeal *within 20 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 attached to this Notice.

- **REQUEST A HEARING.** You can request a Hearing with the DHS Addictions and Mental Health Division. You have two options for requesting a Hearing:
 1. You can request a Hearing instead of filing an Appeal. If you do this, you must request a Hearing *within 45 calendar days from the date of this Notice*. If you request a Hearing instead of filing an Appeal, you lose your right to file an Appeal; **or**

2. You can request a Hearing after you have you have received a decision about your Appeal. If you do this, you must request a Hearing *within 45 calendar days from the date of the Appeal decision.*

Information about how to request a Hearing is attached to this Notice.

You can call [Name of Agency Representative] at [Phone Number] for more information.

Sincerely,

[Name], [Title]
[Agency Name]

Cc: [Provider, where applicable]
File

Enclosures: Text of OAR identified on Page 1 of this letter
How to File an Appeal
Complaint & Feedback Form • Appeal Form
Notice of Hearing Rights

SAMPLE