Medi-Cal Adult Hearing Request Letter (Cut-off Service)

[Your Full Name]

[Your Address]

[Your Telephone Number]

[Date]

[Address][fn]

Re: **[Name of Beneficiary]**, Member # **[Member ID Number]** Claim # **[Claim Number]**

To Whom It May Concern:

I am writing to request a Medi-Cal Fair Hearing for **[Beneficiary]. [Beneficiary]** is enrolled in **[Medi-Cal Program or Managed Care Provider]** in **[County].** In order to ensure continuity of care, **I am requesting aid paid pending** the resolution of the hearing.

On **[date]**, I received a letter saying that **[Beneficiary]** will no longer receive coverage for **[service]** by **[name of provider]**. The reason for denial was listed as **[reason listed for denial]**.

[Note whether the beneficiary changed Medi-Cal plans within the past 12 months. If so, note whether the beneficiary had received these services through his or her previous plan].

[Describe any previous efforts you may have made to appeal the decision internally]

[Service] is medically necessary in order to ensure that **[Beneficiary]** can communicate effectively. **[Beneficiary]** has already benefited from this service by **[describe benefit]** and is continuing to make progress toward **[goal].** It is critical that **[Beneficiary]** continue to receive the service in order to continue making progress toward **[goal]**, avoid loss of functional skills, and retain access to necessary communication supports.

I am attaching a letter from **[Beneficiary]**?s **[type of treatment provider]**, **[name]**, who has determined that this intervention is evidence-based and medicallynecessary due to **[describe specific needs of the beneficiary that will be addressed by the service]**. The intervention will address these needs by **[describe what is involved in the intervention or service]**.

[Add more detailed information if possible. If you are including other documents such as prior assessments, include a list of what you are sending here.]

If you need additional information, I can be reached at **[telephone number and/or e-mail address]**.

Sincerely,

[Signature]

[Typed Name]

[fn] You can either address the letter to:

1. The county welfare department shown on the Notice of Action;
2. The California Department of Social Services, State Hearings Division, P.O. Box 944243, Mail Station 9-17-37, Sacramento, California 94244-2430;
3. To the State Hearings Division at fax number (916) 651-5210 or (916) 651-2789; or
4. Request a Hearing Online [1]

Language
English

OFFICE OF DEVELOPMENTAL PRIMARY CARE

500 Parnassus Ave, Box 0900
San Francisco, CA 94143
Phone: (415) 476-4641**Fax:** (415) 476-6051

- Site Map
- UCSF Main Site

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Links
[1] https://secure.dss.cahwnet.gov/shd/pubintake/cdss-request.aspx