Notice Of Action

Date of Notice

Notice ID Number
Member ID Number

Name of Member
Street Address
City, State and Zip Code

Practitioner Name

Proposed Tx/Condition

Dear [Name of OHP Member]:

This is a notice that [Type of Mental Health Service] will be [reduced/suspended/terminated] on [date]. This [type of treatment] is denied because of [reason for denial].

If you disagree with this decision and you want address the issue, you must do one or both of the following:

File an Appeal. You can file an Appeal. Information about how to file an Appeal is attached to this letter. If you file a Appeal, it must be filed within 30 calendar days of this letter.

Request a hearing. If you request a hearing, you must make the request within 45 calendar days of the date of this letter or, if you go through the Appeal process first, within 45 calendar days of the date of the Appeal decision. If you request a hearing first, you will lose your right to use the Appeal process. Information about how to request a hearing is attached to this letter.

You can call the Member Services Coordinator for more information at 541-298-2101 or 1-800-493-0040, TDD 1(800) 399-7335.

IMPORTANT!

If you want your TYPE OF TREATMENT to stay the same while you wait for the complaint or hearing decision, you must file your complaint or request a hearing by the DATE OF ACTION or within ten calendar days after the date this letter is mailed or given to you, whichever is later. You need to say on your complaint form or hearing request form that you want your benefits/services to stay the same. However, if your benefits/services stay the same and you lose the complaint or hearing, you may be required to pay for the cost of the benefits/services you received from the DATE OF ACTION until the decision.