<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

Member ID: <<Member ID>>; DOB: <<DOB>>
Reference Number: <<Reference #>>; Type of Service: <<Service Category>>

<<Member Name>>,

The following medical service(s) have been approved:

Services	*Quantity and Dates*
<CPT Code Description>	<Quantity and approved date>

The services will be rendered by:
(Authorized Provider Name) (Phone Number)

You may now call this Doctor to make your appointment. Please bring this letter to your appointment.

If you have any questions, please call <IPA> at <Contact Information>.

IMPORTANT NOTICE!
Upon acceptance of referral and treatment of the Member, the Physician/Provider agrees to accept <IPA> Contracted Rates. This referral/authorization verifies medical necessity only. Payments for services are dependent upon the Member's eligibility at the time services are rendered.

Criteria used in making this decision can be requested by calling <IPA> at <Contact Information>.

To your health,

UM Coordinator
cc: PCP
RequestingProvider
Member File

California Department of Health Care Services (DHCS) Office of the Ombudsman
For help with Medi-Cal, you may call the California Department of Health Care Services Ombudsman Office at **1-888-452-8609**, Monday through Friday, 8:00am to 5:00pm, excluding

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holidays. The Ombudsman Office helps people with Medi-Cal understand their rights and responsibilities.