[Insert Provider Name, Address, Phone Number]

**Notice of Dismissal of Pre-Service Request**

[Date]

[Name of Member]

[Address]

|  |
| --- |
| Dear [Name of Member],  We recently received a request for [Insert**:** brief description of requested outpatient care/pre-services].  Unfortunately, we’re not able to process your request at this time.  Here’s why:  [For inadequate AOR:] The Appointment of Representative (AOR) form submitted with the request is not currently valid. [Free text: Include **Why/What is missing** in the form to make it invalid (examples: no signature; out of date) is missing.] Please submit an updated AOR form.  [For invalid requestor:] The person or entity who made the request is not permitted to make such a request for you without the receipt of an adequate Appointment of Representative (AOR) form. Please fill out and submit a current AOR form.  [For death – request from physician:] We have been informed that this member has passed away. Please contact SCAN if this information is inaccurate.  [For timely verbal/written request for withdrawal of their initial determination request:] We have received a request to withdraw the original request. |
| **What you might do next**   1. Appeal this decision. Your appeal must be received within **60 calendar days** of the date of this dismissal notice.   Include a copy of this ***Notice of Dismissal of Coverage Request***along with any supporting information with your appeal and explain why you believe the dismissal was incorrect. Contact our Grievance and Appeals Department to make your appeal. |
| SCAN  Attn: Grievance and Appeals Department  P.O. Box 22644  Long Beach, CA 90801-5644  Tel: 1-800-559-3500  TTY Users Call: 711  Fax: 1-562-989-0958 |
| 1. Ask us to cancel (or vacate) this dismissal action or reconsider your request by contacting our Member Services team or by sending a written request including any additional information that supports your request.   Your request to vacate this dismissal must be received within **6 months** of the date of this notice. Include a copy of this *Notice of Dismissal of Coverage Request* along with any supporting information with your request. |
| [Insert Provider Name, Address, Phone Number] |

**Do You Have Questions?**

SCAN Member Services is ready to help.

Call them at 1-800-559-3500 (TTY: 711).

* Hours from October 1 to March 31: 8 a.m. to 8 p.m., 7 days a week.
* Hours from April 1 to September 30: 8 a.m. to 8 p.m., Monday through Friday.
* Messages received on holidays and outside of our business hours will be returned within one business day.

[C: Requesting Provider Name]

[Requesting Provider Address]

[C: PCP]

[PCP Address]