

Request for Timely Access to Therapy

Your Address

Address of Health Plan

Date

To Whom It May Concern:,

I am writing on behalf of my child, _____ (name), (DOB, Health Plan ID #).
_____ is a member of _____ (medical group) and is a patient of Dr
_____ (primary care doctor).

(If child has an ASD diagnosis):

_____ (child's name) was diagnosed with an autism spectrum disorder on
_____ (date) by Dr _____ (or group/Hospital, or Regional Center).
_____ (child's name) needs the following services: (specify) _____,
_____, and _____ (example, ABA, speech, social skills group).

(If child is suspected of having autism):

_____ (child's name) was screened for autism by Dr _____ on (date)
_____ and it was determined that _____ (child's name) needs an autism assessment.

I have called the health plan and was told _____ (describe). I have called the
following providers on your plans list:
DR A _____ not taking new patients.
Dr B _____ has 6 month wait list
Dr C (describe for each)

No providers are available to see my child.

According to the Department of Managed Health Care's Timely access to care standards, my health plan must get my child mental health care within 10 business days, and 15 business days for other conditions. The Department of Managed Health Care considers getting children with autism into timely treatment an urgent health matter and has included this in previous regulations. Please consider this request for _____ (treatment/assessment) a formal grievance. Please contact me in writing as soon as possible at the address above with names of providers that have autism expertise and availability to see my child. If you do not have anyone in your network that can see my child, please provide me with written permission to see someone out of the network.

Thank you for your cooperation in this urgent matter.
Sincerely,