

Health Plan Logo

Health Plan

Address

Address

Lock-In Assignment Letter

[Member Name]

[Member Address 1]

Date: [date]

[Member Address 2]

Dear [Member Name]:

We previously notified you of your enrollment in the [Health Plan Lock-In Program name]. We requested that you select your provider(s) by XX/XX/XXX. Since we did not receive your response, we have assigned your providers. Your Lock-In Providers are listed below. Your Lock-In will begin on XX/XX/XXXX.

You should go to your Lock-In Primary Care Provider (PCP) to receive all of your medical treatment. If you need to receive services from a specialist, then you should add a specialist provider to your Lock-In enrollment.

You should go to your Lock-In Pharmacy to receive all of your medications. If you need specialty medications, you may add a specialty pharmacy provider. The goal of the Lock-In is to help you use your medications in a healthier way. You may call the [Lock-In Contact] at the toll-free number below with any changes or questions about your Lock-In.

[Lock-In PCP name]

[Address Line 1]

[Address Line 2]

[Phone number]

[Lock-In Pharmacy name]

[Address Line 1]

[Address Line 2]

[Phone number]

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx

Toll Free Phone Number

1-(xxx) xxx-xxxx

Fax Number