Health Plan Logo
Health Plan
Address

Pharmacy Only Lock-In Decision Letter

[Member Name]
[Member Address 1]
[Member Address 2]

Date: [date]

Dear [Member Name]:

Your medical records show that you are not using your Medicaid coverage in a way which is best for your health. [Health Plan name] is placing you in a special program that will help you use your Medicaid in a healthier way. You are being placed in the [Health Plan Pharmacy Only Lock-In Program name]. This program can assist you in managing your medications to stay healthy.

Under this program, you must choose: one pharmacy. You may select a specialty pharmacy provider, if one is needed. You will still be able to get all other Medicaid covered services.

You must provide the name and contact information for the pharmacy you choose as your Lock-In Pharmacy. 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.

We will let you know if the Lock-In Pharmacy you picked is approved. In order to choose a pharmacy by phone, please call 1-(XXX) XXX-XXXX before XX/XX/XXXX between [hours]. If you want to choose your pharmacy by mail, please mail back the enclosed form to: [Health Plan name and address]. We will also notify you by mail of your approved pharmacy. If you do not select your pharmacy or do not appeal the Lock-In decision, you will be assigned your pharmacy. You may still change your pharmacy after assignment, by contacting the health plan.

This change will **NOT HAPPEN** until XX/XX/XXXX (60 days from the date of this notice) to give you, or anyone you want to represent you, time to talk about this decision with [Health Plan name] OR to request an appeal.

Sincerely,

[Lock-In Contact]
[Health Plan Lock-In Contact]
1-(xxx) xxx-xxxx
Toll Free Number

1-(xxx) xxx-xxxx
Fax number [optional]

What can I do if I disagree with the [Health Plan's] decision?
If you disagree with the decision, you (or someone you select to help you) may ask for an appeal. If you want to request an appeal, you must do so within 60 days from the date of this notice.

What happens if you ask for an appeal?

- You tell [Health Plan] why you think the decision to limit your pharmacy is incorrect.
- If you want someone to help you with the appeal, you must give them written permission.
- Until a decision is made about your appeal, you can keep using your current pharmacy.
- After the appeal, if you disagree with the appeal decision you can request a State Fair Hearing. If you accept this decision and do not file an appeal, you cannot later request a State Fair Hearing.

How do you ask for an appeal?
Give us all of the information listed here:

Your name	
Your address	
Your telephone number	
Your date of birth, Social Security number, or member ID number	
Why you think you should be able to keep using your current pharmacy or pharmacies	

Send your request to [Health Plan]. You can file an appeal by mail, phone or fax.
Mail: [Health Plan address]

Phone: [Health Plan toll free number]
Fax: [Health Plan toll free fax number]

How long does it take to make a decision about my appeal?
Most decisions are made within 30 days of requesting an appeal.

Do you need help with this letter? Call [Health Plan] at [Health Plan toll free number.] If you need help in another language, call 1-888-xxx-xxxx (toll-free).

What if you need a fast decision?
If your condition is considered urgent, we may be able to make a decision about your appeal within 72 hours of receipt. You may need a fast decision if, by not getting the requested services, one of the following is likely to happen:

1. You will be at risk of serious health problems, or you may die;
2. You will have serious problems with your heart, lungs, or other body parts; or
3. You will need to go into a hospital.

Your doctor must agree that you have an urgent need.

Para obtener ayuda para traducir o entender esta información, sírvase llamar al **1- 888-xxx-xxxx** o TDD/TTY **1-877-xxx-xxxx**, entre 8 a.m. y 5 p.m.

Để được giúp phiên dịch hoặc hiểu phần này, xin gọi số **1-866-595-8133** hoặc TDD/TTY **1-877-xxx-xxxx** trong khoảng từ 8 giờ sáng - 5 giờ chiều.

Lock-In Pharmacy Provider Selection Form

Instructions: You must provide your Lock-In Pharmacy choice.

If your pharmacy cannot provide specialty medications, such as infusions, you may select a specialty pharmacy. All other services covered by [Health Plan name] will still be available to you.

I, _____ select the pharmacy listed below as my Lock-In Pharmacy.
(Member's Name)

Pharmacy

Name: _____
Address: _____
_____
Phone number: _____

Specialty Pharmacy

Name: _____
Address: _____
_____
Phone number: _____

Signature_____
(Member's signature)

Date _____

Note: You can choose your Lock-In Pharmacy by phone or mail. You can call [Health Plan Lock-In Contact] at 1-XXX-XXX-XXXX between [hours] with your Lock-In Pharmacy choice. You may also mail your Lock-In Pharmacy choice to [Health Plan name and address].