Health Plan Logo
Health Plan
Address
Address

Lock-In Provider [Insert Approval or Denial] Letter

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

Date: [date]

Dear [Member Name]:

Your Lock-In [Insert Pharmacy or Primary Care Provider (PCP)] is [Insert approved or denied.]

Why is my [Insert pharmacy or PCP] denied?
Your Lock-In [Insert Pharmacy or PCP] is denied because [*comprehensive explanation in plain language for why the [PCP or pharmacy] does not meet the criteria to be the member's Lock-In [PCP or Pharmacy*].

You have been assigned a provider. Your provider is 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 [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]

[Lock-In Specialist, if needed]
[Address Line 1]
[Address Line 2]
[Phone number]

Commented [GJ1]: Only use this language for denials.

Commented [GJ2]: Only use this language for assignments

Commented [GJ3]: Please use this language for PCP Lock-In.

Commented [GJ4]: Please use this language for Pharmacy Lock-In.

Sincerely,

[Lock-In Contact]
[Health Plan Lock-In Contact]

1-(xxx) xxx-xxxx
Toll Free Phone Number

1-(xxx) xxx-xxxx
Fax Number