Health Plan Logo
Health Plan
Address
Address

Pharmacy Only Lock-In Request for Call Back

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

Date: [date]

Dear [Member Name]:

We previously notified you of your enrollment in the [Health Plan Lock-In Program name]. We tried to reach you by phone several times to discuss your choice for Medicaid Lock-In Pharmacy. Please call me as soon as possible to discuss your pharmacy choice. You may reach me at the toll-free number listed below between [hours], Monday through Friday.

If you do not choose your pharmacy, your outpatient pharmacy will be assigned.

Sincerely,

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

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

1-(xxx) xxx-xxxx
Fax Number