

Health Plan Logo

Health Plan

Address

Address

## Lock-In Pharmacy Only Denial Letter

[Member Name]

[Member Address 1]

Date: [date]

[Member Address 2]

Dear [Member Name]:

After a review of your records, your Lock-In Pharmacy request is denied.

### **Why is my pharmacy denied?**

Your requested Lock-In Pharmacy is denied because *[comprehensive explanation in plain language for why the pharmacy does not meet the criteria to be the member's lock-in pharmacy]*.

You have been assigned to a pharmacy provider to fill your prescriptions. Your provider is listed below. Your Lock-In will begin on XX/XX/XXXX.

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 your pharmacy Lock-In is to help you manage 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 Pharmacy name]

[Address Line 1]

[Address Line 2]

[Phone number]

Sincerely,

[Lock-In Contact]

[Health Plan Lock-In Contact]

(xxx) xxx-xxxx

Toll Free Phone Number

(xxx) xxx-xxxx

Fax Number