Health Plan Logo
Health Plan
Address
Address

Lock-In Pharmacy Removal Letter

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

Date: [date]

Dear [Member Name]:

After a review of your records, you will be removed from the [Health Plan Lock-In Program name]. Your Pharmacy Lock-In will end on [date]. We will continue to look at your records. If you need more help managing your medications, you will be placed back into the [Health Plan Lock-In Program name].

Sincerely,

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

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

1-(xxx) xxx-xxxx
Fax Number