

[Print rules: This letter contains variable text based on values for the <memberHpCode> elements. Refer to the Plan Code Table.]

[Manifest Keyline]

<dateOfLetter>

Medicaid EDG: <caseID>

To the addressee or guardian of:

[DRS]

<hohName>

[VER]

<addressLine2>

[LTR]

<addressLine1>

<city>, <state> <zipCode> - <zipCodeExt>

[IMB Postal Barcode]

[Always Print]

[Subject: Denial of Enrollment]

Dear <hohName>:

You have asked to join [*planName*], but we cannot place you in [*planName*] because:]

[Print this SECTION when <rsn> is 04]

- [You do not have Medicare Part A (Hospital Insurance). You must have Medicare Part A to join a STAR+PLUS Medicare-Medicaid Plan.]

[Print this SECTION when <rsn> is 05]

- [You do not have Medicare Part B (Medical Insurance). You must have Medicare Part B to join a STAR+PLUS Medicare-Medicaid Plan.]

[Print this SECTION when <rsn> is 06]

- [You do not meet the requirements to join a STAR+PLUS Medicare-Medicaid Plan.]

[Print this SECTION when <rsn> is 08]

- [You have prescription drug coverage through your job or your union. You told us you do not want to join a STAR+PLUS Medicare-Medicaid Plan because your coverage will change.]

[Print this SECTION when <rsn> is 09]

- [You do not have Medicaid. You must have Medicaid to join a STAR+PLUS Medicare-Medicaid Plan.]

[Print this SECTION when <rsn> is 10]

<3x9 barCode image>

<barCode> [Print human readable]

[MODE1]

- [You do not receive Medicaid benefits through the STAR+PLUS program.]

[Print this SECTION when <rsn> is 11]

- [You do not live in an area where this combined Medicare-Medicaid program is available.]

[Print this SECTION when <rsn> is 12]

- [You did not send the facts we asked for by the requested date.]

[Always Print]

[What's next:

You will keep getting your Medicaid and Medicare services the same way you do now. If you think we made a mistake and you should be able to join in a STAR+PLUS Medicare-Medicaid Plan, call 1-877-782-6440.

Need help? Have questions? Call us toll-free.

Call the STAR+PLUS help line at **1-877-782-6440**. You can call 8 a.m. through 6 p.m. Central Time, Monday through Friday. If you still have questions or want to file a complaint, you can call the Ombudsman Managed Care Assistance Team by calling **1-866-566-8989**, 8 a.m. to 5 p.m. Monday through Friday. If you have a speech or hearing disability, call **7-1-1** or **1-800-735-2989**.

Have questions about Medicare or need help with your Medicare services?

Call **1-800-633-4227 (1-800-MEDICARE)**, 24 hours a day, 7 days a week. If you have a speech or hearing disability, call **1-877-486-2048** for TTY service. You can also visit www.medicare.gov.

If you want free advice about your health insurance coverage, call the State Health Insurance Assistance Program at **1-800-252-9240**. You can call Monday to Friday, 8 a.m. to 5 p.m. Central Time.

You can get this document in Spanish or speak with someone about this information in other languages for free. Call 1-877-782-6440. The call is free.

This information is available for free in other languages and formats, like large print, Braille, and audio.

Puede obtener esta carta en español o hablar gratis con alguien sobre esta información en otros idiomas. Llame gratis al 1-877-782-6440.

Esta información está disponible gratis en otros idiomas y formatos, cómo letra grande, Braille, y audio.

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<barCode> [Print human readable]

[MODE1]

MMP Denial of Enrollment Letter
MMP7 - 10/01/19
[Program] - [population] - [custSrvcAreaCode]
[FILENAME] - [letterReqId]
[QUAD] - [BIFILEID] - [BIBATCHID]