

<<IPA LOGO>>

<<Date>>

<<Member Name>>  
<<Address Line 1>> <<Address Line 2>>  
<<City>>, <<ST>> <<Zip>>

Member ID#: <Member ID>  
Health Plan Name: IEHP DualChoice (HMO D-SNP)  
Attending Physician's Name: <PCP>  
Requested Service: <Service>  
Reference Number: <Reference Number>

Dear <Member Name>:

We hope this letter finds you well. We want to let you know you that <Medical Group/IPA>, under contract with IEHP DualChoice, does not need to authorize the above requested service(s). IEHP DualChoice has contracted with <Carve Out Provider> to provide this service to you.

To get <services(s)>, please call < Carve Out Provider > directly at <telephone number of responsible entity> or TTY number <TDD/TTY number> during the hours <insert hours available>. Again, you do not need approval from <Medical Group/IPA> to get <service(s)>.

If you have any questions, you can call << Medical Group/IPA >> << Medical Group/IPA telephone number>>, << Medical Group/IPA hours of operation>>. TTY users should << Medical Group/IPA TTY number>>. We will be happy to help you.

Thank you for being a valued Member of << Medical Group/IPA >> and for trusting us with your health care needs.

To your health,

<<Medical Group/IPA>>

cc: Patient File  
Requesting Physician  
Primary Care Physician  
IEHP DualChoice

*IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.*