

Sample Extended Transitional Medical Assistance Closing Letter

Name  
Address  
Address

Date:

Dear

Your MC+ healthcare coverage for the following person(s) ended \_\_\_\_\_ as you exhausted the twenty-four (24) months of benefits allowed under the Extended Transitional Medical Assistance program per 13 CSR 70-4.090. We do not have any information that indicates eligibility for any other MC+ or medical assistance program.

*You may call 1-800-TEL-LINK (1-800-835-5465) to identify where to go for family planning services and a variety of other services for families.*

You have the right to appeal decisions made involving your coverage. You can request a hearing within 90 days from the date of this letter by contacting your MC+ Service Representative. If you request a hearing, you may present your information yourself or be represented by your own attorney or by other persons who know your situation. You have the right to present witnesses in your behalf and to question witnesses who appear at the request of the MC+ Service Representative.

Sincerely,

MC+ Service Representative