FAMILY SERVICES OFFICE
XXXXXXXXXXXX
XXXXXXXXXX XX XXXXX-XXXX

(STATE SEAL)

XXXXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXAXXX XX XXXXX

03/24/2003

CASE ID: XX XXXXXXXX

Dear MC+ Customer:

Effective April 1, 2003, children listed below are now eligible to receive non-emergency medical transportation. The reason for this change is the MC+ income limits have increased.

If you agree with this, no further action is required of you. If you do not agree with this action, 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, we will schedule it for you and notify you of the time of the hearing. You may present your information yourself or you may 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,

XXXXXXXXXXXXXXXXXXX
MC+ Service Representative
Load # XXXXX
Phone # XXX-XXX-XXXX

Child's Name	Medicaid/MC+ Number
XXXXXXXXXXXXXXXXXXX	XXXXXXXX
XXXXXXXXXXXXXXXXXXX	XXXXXXXX

OIFIM34P/PIFIM31P

FAMILY SERVICES OFFICE
XXXXXXXXXXXXX
XXXXXXXXXX XX XXXXX-XXXX

(STATE SEAL)

XXXXXXXXXXXXXXXXX
XXXXXXXXXXXXXX
XXXXXXXAXXX XX XXXXX

03/24/2003

CASE ID: XX XXXXXXXX

Dear MC+ Customer,
Effective April 1, 2003, you are no longer required to pay a $5 co-pay for provider visits and are eligible to receive non-emergency medical transportation for your child(ren) listed below. The reason for this change is the MC+ income limits have increased.
If you agree with this, no further action is required of you. If you do not agree with this action, 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, we will schedule it for you and notify you of the time of the hearing. You may present your information yourself or you may 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,

XXXXXXXXXXXXXXXXXXXXXXXMC+
Service RepresentativeLoad #
XXXXXPhone # XXX-XXX-XXXX

Child's Name	Medicaid/MC+ Number
XXXXXXXXXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX

OlFIM31P/P1FIM31P

FAMILY SERVICES OFFICE
XXXXXXXXXXXX
XXXXXXXXX XX XXXXX-XXXX

(STATE SEAL)

XXXXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXAXXX XX XXXXX

03/24/2003

CASE ID: XX XXXXXXXX

Dear MC+ Customer,
Effective April 1, 2003, you are no longer required to pay a $5 co-pay for provider visits for your child(ren) listed below. The reason for this change is the MC+ income limits have increased.
If you agree with this, no further action is required of you. If you do not agree with this action, 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, we will schedule it for you and notify you of the time of the hearing. You may present your information yourself or you may 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,

XXXXXXXXXXXXXXXXXXXMC+ Service RepresentativeLoad # XXXXXPhone # XXX-XXX-XXXX

Child's Name	Medicaid/MC+ Number
XXXXXXXXXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX

O1FIM31P/P1FIM31P

FAMILY SERVICES OFFICE
XXXXXXXXXXXX
XXXXXXXXXX XX XXXXX-XXXX

(STATE SEAL)

XXXXXXXXXXXXXXXX
XXXXXXXXXXXXX
XXXXXXXAXXX XX XXXXX

03/24/2003

CASE ID: XX XXXXXXXX

Dear MC+ Customer,
Effective April 1, 2003, you are no longer required to pay a premium to receive MC+ coverage for the children listed below. These children's co-pay will now be $5 for provider visits. The reason for this change is the MC+ income limits have increased.If you agree with this, no further action is required of you. If you do not agree with this action, 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, we will schedule it for you and notify you of the time of the hearing. You may present your information yourself or you may 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,

XXXXXXXXXXXXXXXXXXX
MC+ Service RepresentativeLoad
XXXXXPhone # XXX-XXX-XXXX

Child's Name	Medicaid/MC+ Number
XXXXXXXXXXXXXXXXXXX	
XXXXXXXXXXXXXXXXXXXXXXXXXXXX	XXXXXXXX

O1FIM31P/P1FIM31P