**[Health Plan Logo]**

**Notice of Provider Restriction**

**«Date»**

**«Memb\_First» «Memb\_Last»**

**«Mailing\_Add\_1»**

**«Mailing\_add\_2»**

**«Mailing\_add\_3»**

 **(Member ID Number)**

Dear (**Member** **Name**):

We are writing to tell you about a change to the (drug store where you get your medicine or doctor who orders your medicine).

Our records show that you use different drug stores to get your medicine. Our records also show that you have different doctors ordering your medicine. We want you to be healthy. We are working with the doctors who order your medicine to make sure you are only taking the medicine you need. You will only be able to use one (pharmacy *or doctor to order your medicine***)**. **You will be assigned to the following on (Date)**:

**(Pharmacy or Physician Name)**

**(Address)**

**(Phone Number)**

If your assigned drug store does not have the medicine you need, you will be able to get an emergency supply from another drug store. If you will be getting your prescription from another Pharmacy because of an emergency, the pharmacy will need to contact (*Contractor’s Pharmacy Benefit Manager*) for an emergency supply approval.

If your assigned drug store is closed, please contact (*Health Plan Name*) at (*Health Plan Customer Service 800 phone number or pharmacy after hours phone number*) for help with finding a pharmacy that is open to get your medication.

**What should you do next?**

Please call your doctors as soon as you can and ask that the orders for your medicine be sent to your assigned drug store. If you would like to use a different (*pharmacy or doctor*), please contact Member Services at:

1-xxx-xxxx, (TTY: 771) Monday through Friday, within **30 days** of the date of this letter to make the change.

This will be in effect for up to a 12-month period. We will review your records after 12 months. At that time we will let you know if you are still limited to (*pharmacy or doctor*).

We based this decision on the following:

* Federal Regulation 42 CFR 431.54 that states when a member overuses a service, the health plan may restrict the member to a chosen provider.

* AHCCCS Medical Policy Manual, Chapter 300.

If you do not agree with this decision, you may submit a written request for a State Fair Hearing. Your written request must be received on or before **(DATE)**. If you need assistance, you may call us at (*phone number*). Your written request for State Fair Hearing must be addressed to:

**Health Plan**

**Grievance and Appeals**

**Address**

**City, State Zip**

We must receive your request no later than **30 calendar days** after the date of this Notice. If the 30th day falls on a weekend or holiday, then we will use the next business day. If we do not receive your request on time, you will not be able to file a request for State Fair Hearing about this Notice.

Sincerely,

If you have trouble reading this notice because the letters are too small or the words are hard to read, please call our office at XXX-XXX-XXXX and someone will help you. If this notice does not tell you what we decided and why, please call us at XXX-XXX-XXXX. This notice is available in other languages and formats if you need it.

Si tiene problemas para leer este aviso porque las letras son muy pequeñas o las palabras son difíciles de leer, por favor llame a nuestra oficina al XXX-XXX-XXXX y alguien le ayudará. Si este aviso no le informa sobre la decisión que tomamos ni el por qué, llámenos al XXX-XXX-XXXX. Este aviso está disponible en otros idiomas y formatos si lo necesita.