

Date>

<Member Name>

<Member Address>

<Member Address>

<Member Address

DOB: <Member Date of Birth>

Dear: <Member Name>

During our recent conversation, you stated that you would like to make a change to your service plan. Your care plan has been updated with this change. Along with this letter, please find two copies of your updated care plan that reflects the change. One copy is for you.

We discussed the need to share your updated care plan with the involved provider. Please sign and return this letter, along with a copy of your signed care plan, in the enclosed envelope to show that you agree with the care plan changes and to have your care plan shared, either full or partial per our discussion, with the provider.

Sincerely,

<Care Coordinator Name, Title>

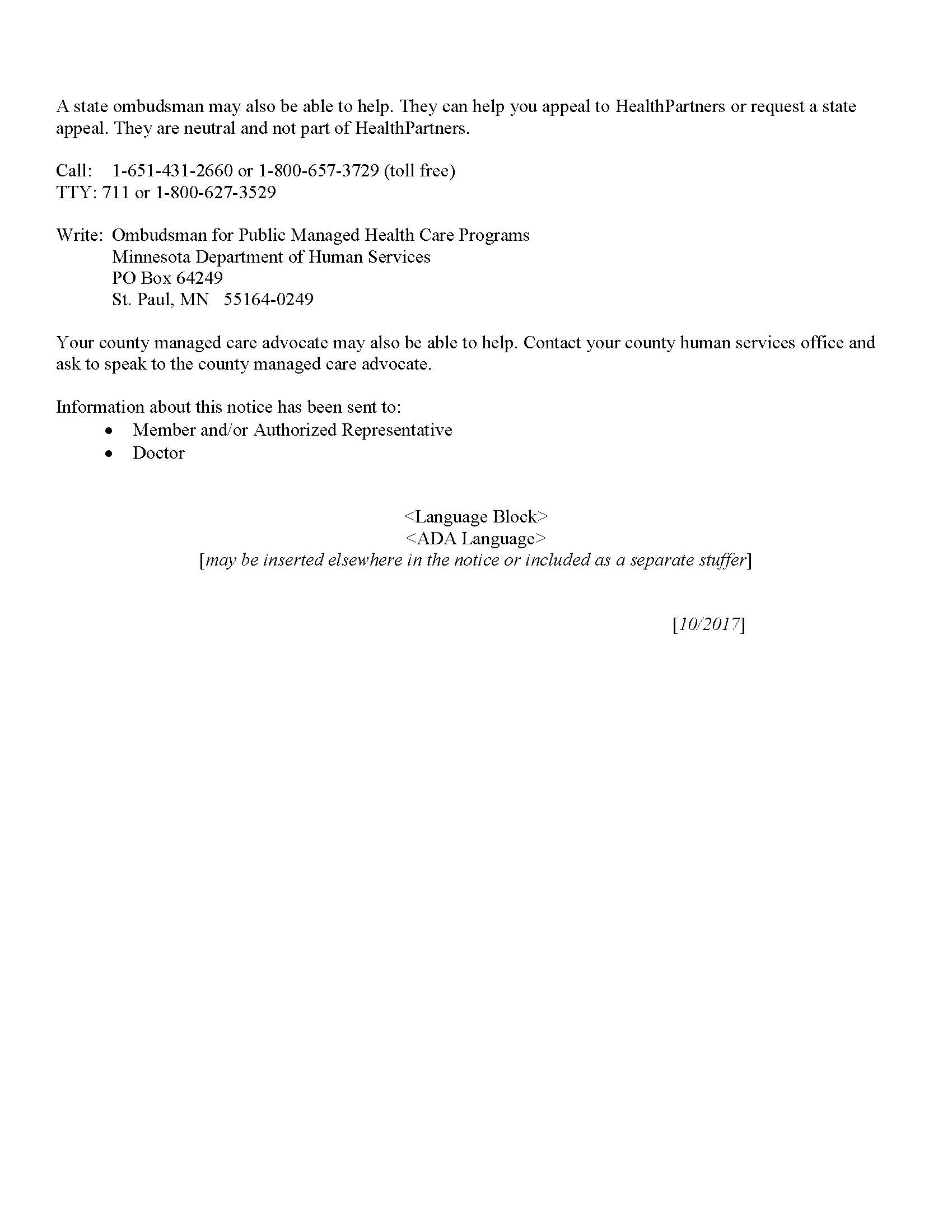
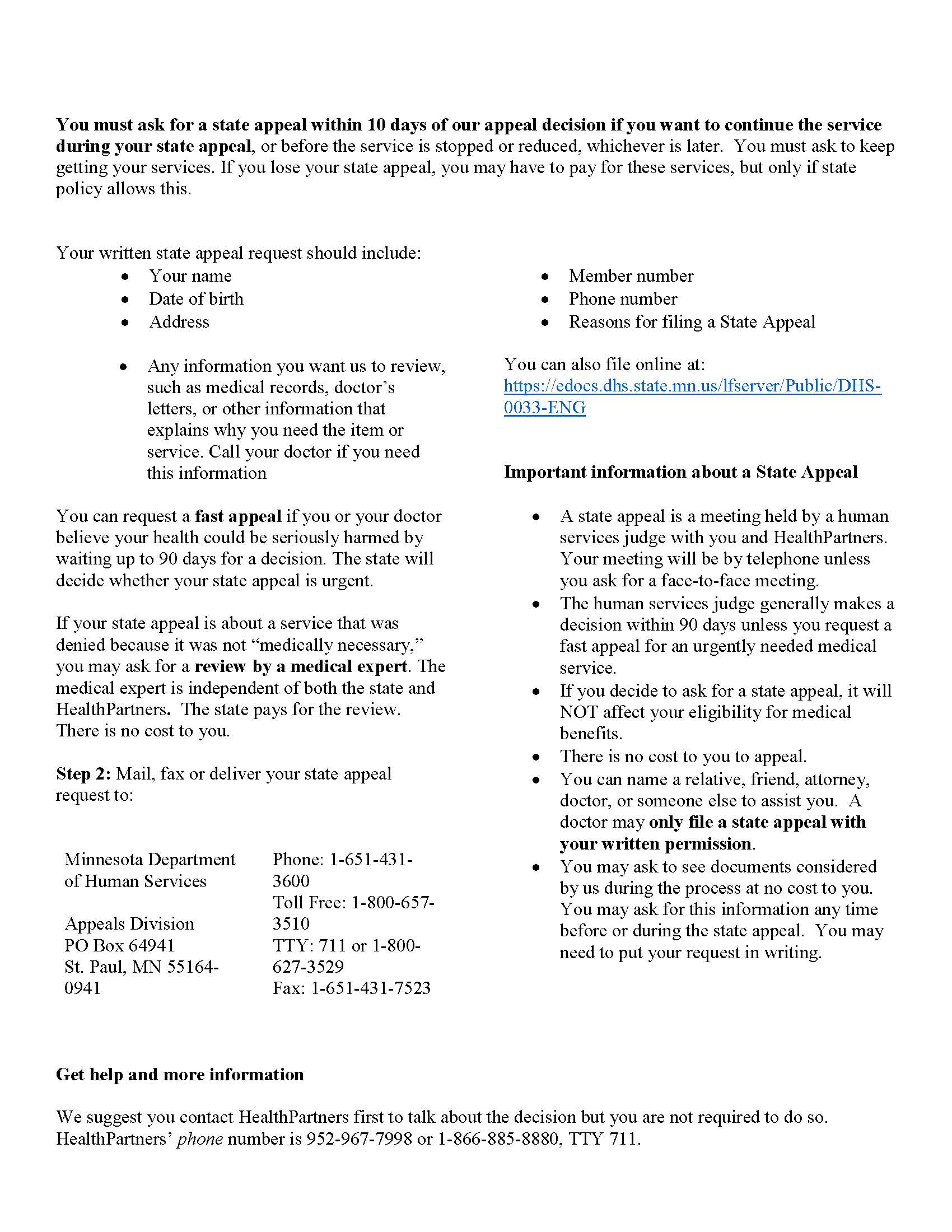
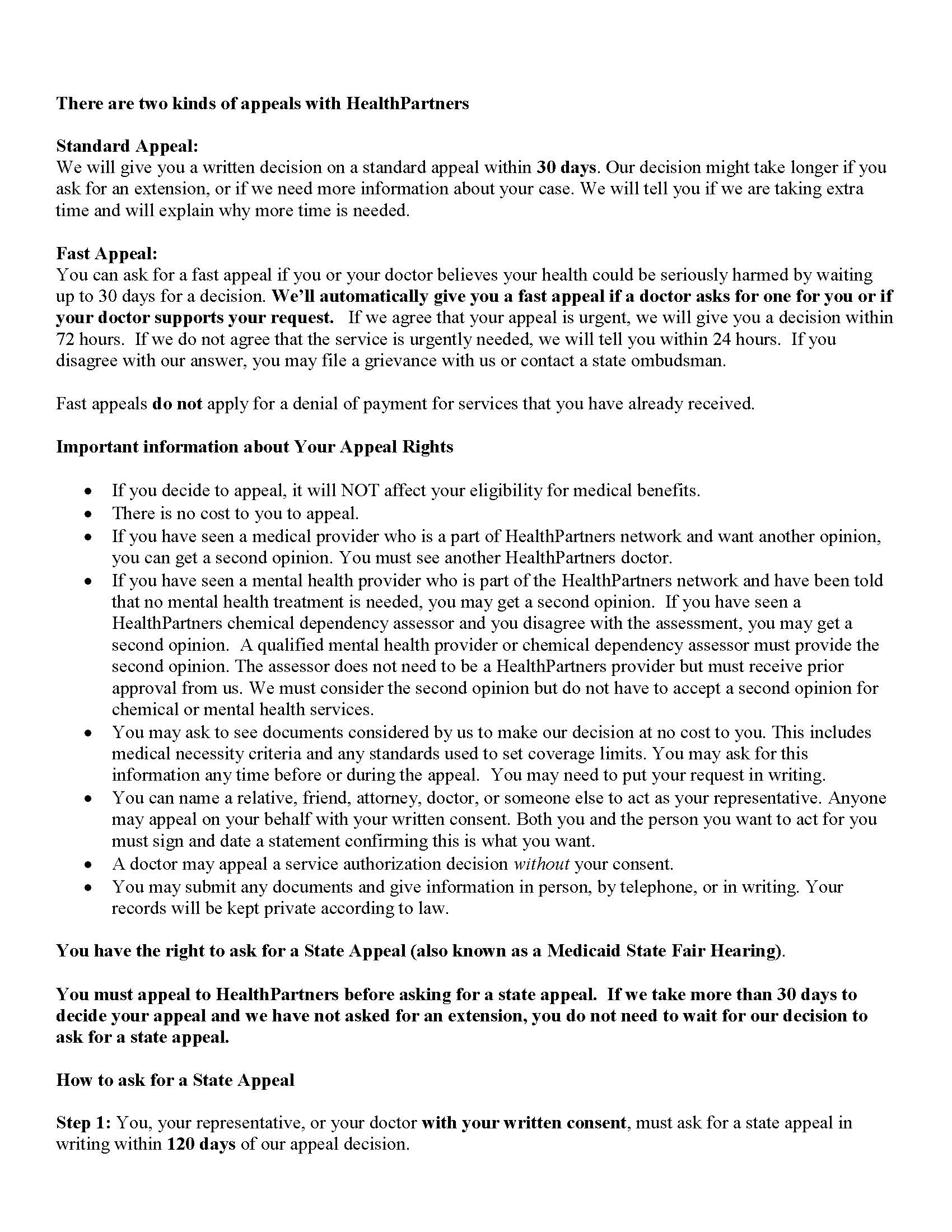
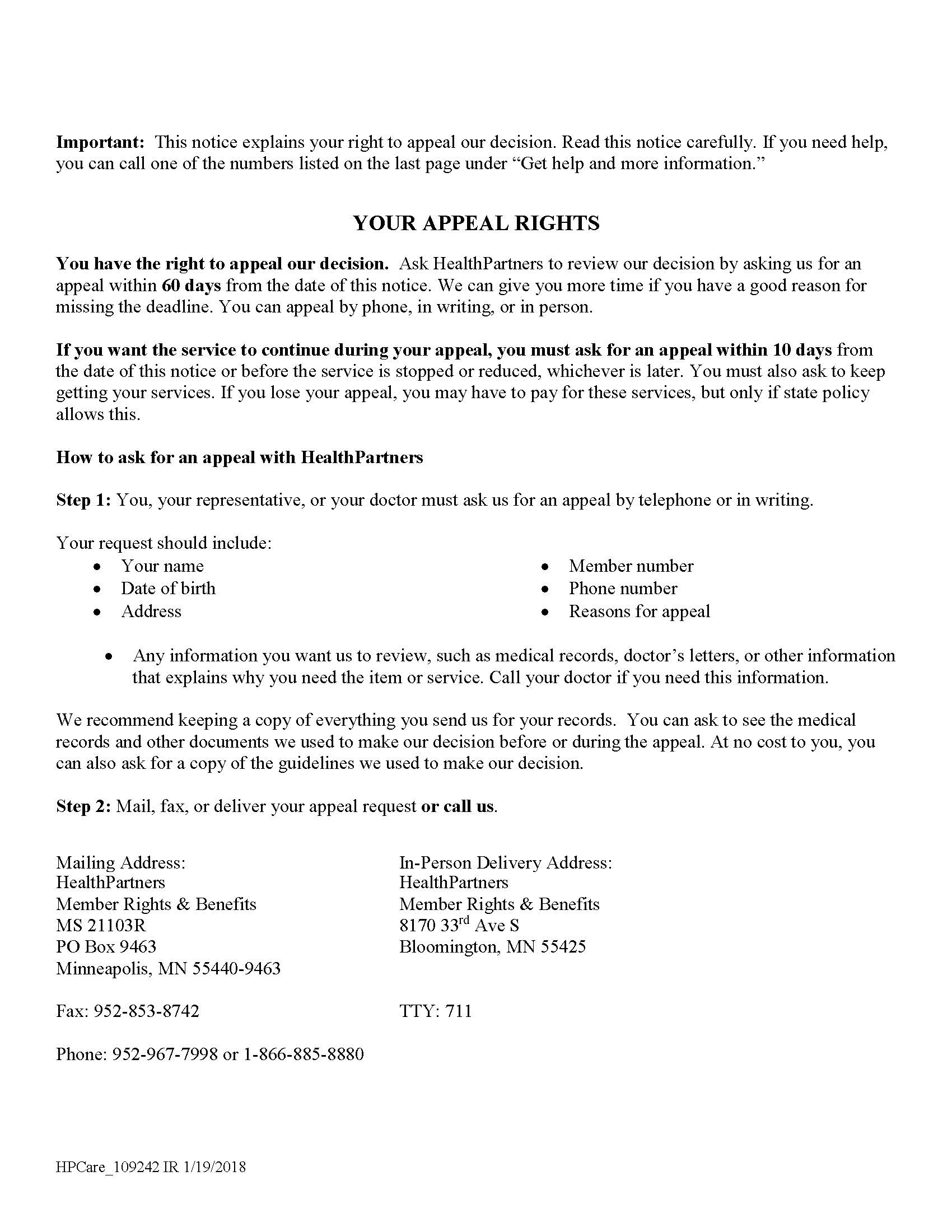
<HealthPartners Disease and Case Management>

Member Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Enclosures: Care Plans, MSHO Integrated Appeal Rights, Statement of Nondiscrimination for Health Plan Members, Language Block, self-addressed stamped envelope.

H2422\_106997 DHS Approved 12/20/2017

Limitations and restrictions may apply. For more information, call Member Services or read the Member handbook. Benefits may change on January 1 of each year. HealthPartners is a health plan that contracts with both Medicare and the Minnesota Medical Assistance (Medicaid) program to provide benefits of both programs to enrollees. Enrollment in HealthPartners depends on contract renewal.



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