MC+ ADVANCE ACTION NOTICE

FROM	**MC+ SERVICE CENTER**		DATE
	STREET ADDRESS		
	CITY	MISSOURI	ZIP
TO	NAME	POLICY HOLDER NAME	
	ADDRESS (STREET OR P.O. BOX NO.)	POLICY NUMBER	
	CITY STATE ZIP		

BASED ON THE INFORMATION WE HAVE ABOUT YOUR ELIGIBILITY WE MUST

☐ discontinue MC+ health care coverage for ______________________________

The last day of MC+ health care coverage is ___________ (MONTH) ___________ (DAY) ___________ (YEAR)

☐ Require you to pay a premium to continue to receive MC+ health care coverage for ______________________________

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The premium amount will be based on your family size of _____ and monthly income of ______________. You will receive information about the amount of your monthly premium and how to pay the premium within 2 weeks.

The reason for this proposed change is that: ______________________________

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If you believe this decision is wrong or if you have more information you believe will prove your need to receive your present coverage, you have until ___________ (DAY OF WEEK) ___________ (MONTH) ___________ (DAY OF MONTH) ___________ (YEAR) to request a hearing. If you wish to request a hearing by mail, you may fill out and return the tear-off form below. To request a hearing by telephone call ___________________________ .

If you request a hearing by this date, your coverage will continue pending the resolution of the hearing. We will notify you of the time and place of the hearing. At the hearing, you may present your information yourself or you may be represented by your own attorney or by other persons who are aware of your situation. If you do not have an attorney, or cannot afford one, and live in an area served by a legal aid or a legal service office, you may be eligible for this service. For the possibility of free legal services call ___________________________ . You have the right to present witnesses in your own behalf and to question witnesses who appear at the request of the MC+ Service Representative.

If you agree with this decision, you do not have to request a hearing. If you do not request a hearing, we will discontinue or change MC+ coverage following the date indicated above.

MC+ SERVICE REPRESENTATIVE	TELEPHONE

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IF YOU WANT A HEARING, FILL OUT THIS FORM, TEAR IT OFF AND MAIL IT TO:		
NAME OF PERSON REQUESTING HEARING	ADDRESS	
TELEPHONE NUMBER WHERE YOU CAN BE REACHED	YOUR SIGNATURE	TODAY'S DATE
USE THIS SPACE TO TELL US WHY YOU DISAGREE WITH THIS DECISION.		

FOR OFFICE USE ONLY

POLICY #	MC+ SERVICE REPRESENTATIVE	LOAD NO.	DATE NOTICE SENT	DATE REQUEST RECEIVED