**Date:**

**CERTIFIED MAIL**

Name\*\*\*\*\*

Address\*\*\*\*\*

City, State Zip\*\*\*\*\*\*\*

RE: Placement into the South Carolina Medicaid Pharmacy Lock-In Program for:

 **Member Name: XXXXX Medicaid ID Number: XXXXXXX**

**This program does not affect your eligibility for Medicaid, only how Medicaid prescription drugs are purchased.**

Based on claims history data from: dd/mm/yyyy thru dd/mm/yyyy, you are being enrolled in the South Carolina Medicaid Pharmacy Lock-In Program. This program was designed to assist Medicaid members whose claims history indicates a need for better coordination of medical care to assure they get the right medicines to stay healthy.

Beginning on the Effective Start Date below, the Lock-In Pharmacy at the address specified below will be the only location where Medicaid will pay for prescriptions. Medicaid will not pay other pharmacies. You will need to transfer all Medicaid prescriptions from other pharmacies to the Lock-In Pharmacy below. If you need assistance, please speak to your pharmacist.

Effective Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lock-In Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Lock-In Pharmacy was selected for you based on 6 months of your recent claims data. If you wish to choose a different pharmacy, you must call ###-###-#### with the name, address and phone number of the pharmacy of choice **within 20 days** from the date of this letter. After the Effective Date, all changes require a request and approval.

You have 30 days from receipt of this letter to file an appeal if you believe the claims Medicaid paid and reviewed for the above 6 month period contain an error. Your appeal must be in writing and include a copy of this letter. Send to:

Director of Appeals and Hearings

XXXXXXXXXXXXXXXX

XXXXXXX

XXXXXXXXXXXXXX

If you have any questions concerning this letter or the Pharmacy Lock-In Program, please call XXXXXX at ###-###-####.

 Thank you,

 XXXXXXX, Supervisor

 Department XXXXXX

PLEASE REMEMBER TO INCLUDE SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT ADDENDUM IN YOUR 30-DAY NOTIFICATION LETTER TO THE MEMBER.