Date

Name\*\*\*\*\*

Address\*\*\*\*\*

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

RE: Removal from the South Carolina Medicaid Pharmacy Lock-In Program for:

**Name: \*, MID#: \***

On \*\*mm/dd/yyyy\*\*, your two-year pharmacy lock in period will expire, and you will no longer be restricted to using only one pharmacy.

Please be advised that your future use of pharmacies will be monitored by the SC Department of Health and Human Services. If deemed necessary, you may be placed back in the Pharmacy Lock-In Program at any time in the future.

If you have any questions regarding this letter please call xxxxx at ###-###-####.

 Thank you,

 XXXXX, Supervisor

 Department XXXXXXX