<Date>

<Member Name>

<Member Address>

<Member Address>

<Member Address>

<Health Plan ID Number>

Dear <Member Name>,

During our recent talk, you said you would like a . Your documents have been updated to show this change. Along with this letter, please find a copy of your updated  that reflects the change.

We discussed the requirement and purpose of sharing your care plan information and support instructions with this provider. Per our discussion you have chosen to

Please sign and return this letter to show you agree with the changes. If you have any questions you can contact me at the number listed below.

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

My Signature Date

Sincerely,

<Care Coordinator Name>

<Care Coordinator Job Title>

<County or Agency Name>

<Phone Number>

<E-mail Address>

UCare's MSHO (HMO SNP) 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 UCare's MSHO depends on contract renewal.

MSC+ H2456\_020918 DHS Approved (02092018) U7724A (11/18)



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