<<IPA LOGO>>

NOTICE OF AUTHORIZATION OF SERVICES

<<Date>>

<<Member Name>>
<<Address Line 1>> <<Address Line 2>>
<<City>>, <<ST>> <<Zip>>

DOB: <MM/DD/YYYY>
Member ID: <Member ID>
Health Plan: IEHP DualChoice (HMO D-SNP)
Requesting Physician: <Physician Name>
Requested Physician: <Physician Name>
Authorization/Precertification Number: <Authorization #>

Dear <Member>:

We hope this letter finds you well. We're writing to let you know we received the request for the services listed below from you or your Provider. We're happy to tell you we have approved the requested services.

> **Authorized Service:** <Authorized Services>
> **Number of Authorized Services:** <# of Services>
> **Authorization Valid from/to:** <MM/DD/YYYY / MM/DD/YYYY>
> **Authorized Provider:** <Servicing provider Name> <Servicing Provider Phone Number>

Please know if you should need more services in the future, such as office visits, treatments, tests or surgery, you will first need approval from <<IPA>>. It is very important to get approval from <<IPA>> before you see a specialist/service Provider. If you don't have an approval in advance, then you may have to pay for these services yourself.

<<IPA>> will review the request for services based on your IEHP DualChoice benefits and medical need. You must be eligible for the services/benefits at the time of service.

Should you have any questions or need more information, please call <<IPA>> at **<<IPA Phone Number>>** <IPA Hours of Operartion>>. TTY users should call **<<IPA TTY Number>>**.

Thank you for being a valued Member of <<IPA>> and for trusting us with your health care needs.

To your health,

<<IPA>>

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IEHP DualChoice (HMO D-SNP) is a HMO plan with a Medicare contract. Enrollment in IEHP DualChoice (HMO D-SNP) depends on contract renewal.

cc: Requesting Physician
        Requested Physician
        Primary Care Physician

Requested Physician: please confirm the Member's eligibility prior to service. The service is approved only if Member is eligible at the time of service.