**MUST BE ON** **PROVIDER’S LETTERHEAD**

DATE

**Re: Recipient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Medicaid ID#:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **DOS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Dear DMAS:

This is to advise you that **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (“Provider”) has engaged **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (“Contractor”), to assist with the appeal of the DMAS denial of reimbursement for services rendered to the above referenced Recipient, on the above referenced dates of service.

There is no cost to the patient for this service. The Provider’s Business Associate Agreement, (“Agreement”), with Contractor has been executed, and the Agreement fully complies with all requirements of the Health Insurance Portability and Accountability Act of 1996.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is our contact with the Contractor, and will be writing letters on behalf of the Provider. He/She is fully authorized to speak directly to you on behalf of the Provider in regard to the appeal filed for the above referenced DOS.

If you have any questions, please do not hesitate to contact me.

 Sincerely,

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

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_of Provider