ATTACHMENT XV

FAMILY HEALTH PLUS
DENIAL OF YOUR REQUEST TO JOIN A HEALTH PLAN

CASE NAME (And C/O Name if Present) AND ADDRESS		
DATE	**UNIT OR WORKER NAME**	**UNIT/WORKER PHONE #**

NAME _____ **CIN** _____

NAME _____ **CIN** _____

We received your Enrollment Form to join a Family Health Plus health plan. You **cannot** join this Family Health Plus health plan because you have picked a plan that is not Family Health Plus. Please look over your enrollment packet and pick a plan that is Family Health Plus. You can only get services from Family Health Plus by joining a Family Health Plus health plan.

Please return the Enrollment Form by _____ to:

_____

_____

_____

If you have any questions call the phone number listed above.