<<today\_date\_mmmm\_ddyyyy>>

**Important Medica Information**

<Member Name>

<Address 1>

<Address 2>   
<City>**,** <State> <ZIP>

**I’ve Tried to Contact You**

Dear <Member Name>,

My name is <Care Coordinator name> and I am your Care Coordinator. I have been trying   
to contact you, but have not been able to reach you.

As a Care Coordinator, I am here to help. My role is to make sure that your health plan is   
working for you. I am available to:

* Review your health care needs with you over the phone or in-person
* Provide support for and information about covered services or supplies to help keep you   
  safe and healthy in your home
* Answer questions about your insurance
* Help you find a provider, such as a doctor or dentist, to meet your unique needs

I can also help you schedule a free physical at your clinic. To schedule an appointment, please   
call me at <CC phone number> <Monday – Friday> between <9 a.m. to 5 p.m.> TTY: 711.

I have included a copy of a Member Engagement Questionnaire. Please fill it out and return it in the included envelope. I have also included a document that provides you with more information about my role as your Care Coordinator and how I can help you with your medical, social and everyday needs.

<Free text for member specific information>

**Questions?**

Please call me at the phone number listed above. If you’d like, a friend or family member may call for you.

For general questions, call:

Medica Member Services at 1-877-379-7540 between the hours of 8 a.m. to 9 p.m. Central, Monday through Friday. **TTY: 711**. Please note that access to a representative may be limited during certain times of the year.

Sincerely,

<Care Coordinator Name>, <Credentials>

<County/Care System/Agency name>

<CC phone number>

cc: member records

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