

from the date you receive this letter to request an appeal. If you do not request an appeal, you may lose the right to a hearing. Please see the enclosed appeal form for complete instructions.

After completing Sections I and II on the enclosed form,

Please **MAIL** to:

EOHHS/ Medicare-Medicaid Plan [This address is for mail only.]
Hazard Building LL B23, 74 West Road
Cranston, RI 02920-8409

Or **FAX** to: (401) 462-3158

If you need help in person or to hand deliver your appeals form, please go to a local Rhode Island Department of Human Services (DHS) Office. If you have questions about completing the form or locating a DHS Office, please call the Medicare-Medicaid Plan Enrollment Line at 1-844-602-3469 (TTY 711), Monday- Friday, 8:30 am- 7:00 pm, Saturday 9:00 am- 12 noon.

[Insert appeals form here]

[<Marketing Material ID: 011 ACKNOWLEDGEMENT OF REQUEST TO CANCEL ENROLLMENT>]