Title: Medi-Cal/Health Coverage Application Reminder Letter

Standard Header

**IMPORTANT: YOUR MEDI-CAL APPLICATION MAY BE DENIED IF YOU DO NOT RESPOND TO THIS LETTER**

As of <Current Date>, we have not received your completed Medi-Cal/Health Coverage application. We cannot decide if you are eligible without your completed application. Your completed application is due no later than <Date>. You may return the information/forms in the following ways:

* Mail \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Online \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* In person at your local county office

We need the following forms and information from you in order to evaluate your eligibility:

If we do not hear from you within 10 days of the date of this letter, we will deny your application. You may reapply at any time.

Once you have given us what we asked for, you may be asked to give more information.

If you have questions or need assistance, please contact the county at the number listed above.

We are looking forward to hearing from you!