<<ENROLLEE NAME>>

<<ADDRESS>>

<<ADDRESS>>

<<CITY, STATE, ZIP>>

<<LETTER DATE>>

Dear << ENROLLEE NAME>>

You were sent information from the Agency for Health Care Administration (AHCA) regarding the Statewide Medicaid Managed Care (Medicaid) program. Soon, you will receive your Medicaid services through a new Medicaid plan.

As an enrollee of <<Health Plan Name>>, we must inform you that we will not serve in the Medicaid program in <<Affected County>>. You will continue to receive services as you do now, until your enrollment with us ends on 01/31/2025. You will then receive your services through your new Medicaid plan.

You were also sent information from AHCA about your Medicaid plan choices. Please be sure to read the information carefully so you choose the Medicaid plan that best fits your needs. For more information about your plan choices, please go online to: [www.flsmmc.com](http://www.flsmmc.com) or call the Florida Statewide Medicaid Managed Care toll-free helpline at 1-877-711-3662.

Sincerely,

Member Services, <<Health Plan Name>>

<<Health Plan Member Services Phone Number>>