Iowa Department of Human Services

MEDICAID NOTICE TO COOPERATE

Date:

To: From:

RE:

Dear :

To date, I have not heard from you or received the questionnaire sent to you on , regarding Medicaid assistance for the above named person.

Please note that non-cooperation will result in cancellation of those benefits or possible denial of future benefits.

If you have questions or need assistance in completing the questionnaire, please call me collect, if necessary, at the above listed number.

If I do not hear from you by , I will assume you do not wish to cooperate in completing the review and the local agency will be notified of non-cooperation and will cancel or deny benefits. We will then attempt to complete the review without your assistance.

Sincerely,

Quality Control Reviewer
Iowa Department of Human Services