P.O. Box 31370
Tampa, FL 33631-3370

<<Date>>

<<Provider_Name>>
<<Provider Address Line 1>>
<<Provider Address Line 2>>
<<Provider City>>, <<Provider State>> <<Provider Zip>>

RE: Notice of Adverse Benefit Determination

Dear Provider,

Thank you for your continued partnership.

Enclosed is your copy of the Notice of Adverse Benefit Determination letter sent to the member with the determination of requested services. Please keep this copy in the member's medical record.

If we can further assist you, please contact the Provider Hotline at **1-866-231-1821**, Monday through Friday, 7 a.m. to 7 p.m.

Sincerely,

Utilization Management Department

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