Eligibility Confirmation for Medical Assistance

Date: [Insert Date]

Recipient's Name: [Recipient's Name]

Recipient's Address: [Recipient's Address]

Dear [Recipient's Name],

We are pleased to inform you that your application for medical assistance has been reviewed and you are eligible for the program. This confirmation provides you with access to the necessary medical support and services needed for your health management.

Your eligibility is effective as of [Insert Effective Date] and will remain in effect until [Insert Expiration Date], provided you continue to meet the program requirements.

If you have any questions or require further assistance, please do not hesitate to contact our office at [Insert Contact Information].

Sincerely,

[Your Name]

[Your Title]

[Organization Name]

[Contact Information]