

# Medicaid Coverage Denial Explanation

Date: [Insert Date]

To: [Recipient's Name]

[Recipient's Address]

Dear [Recipient's Name],

We are writing to inform you of our determination regarding your recent application for Medicaid coverage for essential health benefits.

After a thorough review of your application and related documents, we regret to inform you that your request for coverage has been denied. This decision was based on the following reasons:

- [Reason for denial 1]
- [Reason for denial 2]
- [Reason for denial 3]

If you believe this decision is incorrect, you have the right to appeal. To initiate an appeal, please follow the instructions outlined in the attached documentation. You must submit your appeal within [Insert Timeframe].

For any questions or further assistance, please do not hesitate to contact us at [Insert Contact Information]. Our team is here to help you.

Thank you for your understanding.

Sincerely,

[Your Name]

[Your Title]

[Your Organization]