

CNS Paragraph Form

Date: 04.08.2015

Program Area **03** **(01=PA, 02=FS, 03=MA, 04=HP)**
Paragraph Number **C0065**
Version Number **00006**
Effective Date **2016** **(YYMMDD)**
Title **Disc, Unable to Get Info Reason not Good - Intro**
Comment
Reason Code **U21**

We will discontinue Medicaid/Refugee Medical Assistance/Family Planning Benefit Program effective _____ for:

Name	Client I.D. #
Name	#
Name	#

This is because we must have certain things to decide if you can continue to get Medicaid/Refugee Medical Assistance/Family Planning Benefit Program. You did not give us all the things we need to decide if you can get Medicaid/Refugee Medical Assistance/Family Planning Benefit Program. You failed to provide:

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Suspenderemos Medicaid/Refugee Medical Assistance/Family Planning Benefit Program con vigencia el _____ para:

Nombre	# de ID del cliente
Nombre	#
Nombre	#

Esto es porque debemos obtener ciertas cosas para decidir si debe continuar recibiendo Medicaid/Refugee Medical Assistance/Family Planning Benefit Program. No nos proporciono todas las cosas que necesitamos para decidir si puede recibir Medicaid/Refugee Medical Assistance/Family Planning Benefit Program. No proporciono: