Office of Public Assistance
PO BOX 202925

Helena, Montana 59620-2959

**DEPARTMENT OF
PUBLIC HEALTH AND HUMAN SERVICES**

Greg Gianforte
GOVERNOR

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STATE OF MONTANA

www.dphhs.mt.gov

PO BOX 4210
HELENA, MT 59604-4210

Case #:
Document #:
Print Date:
Contact Phone: 1-888-706-1535
Contact Fax: 1-877-418-4533
Contact Website: apply.mt.gov

About Your Case

Dear [NAME],

The first part of this letter is a summary of your benefits.

Please read this entire letter.

Health Coverage

Your health coverage information is listed below.

Effective Date	Action	Person(s)	Explanation
[DATE]	Approved	[NAMES]	Your renewal has been completed and we found you are eligible for health coverage. For more information, please see the **Your Health Coverage Change Reporting Requirements** section below.

Your Health Coverage Change Reporting Requirements

You must report changes that might affect your health coverage within 10 days of the change. Changes that must be reported for you and other people in your household are:

- Change of address
- Change in marital status (marriage or divorce)
- Change in household composition (someone moves in/out, becomes pregnant or adopts a child)
- Change in income

You can report changes by:

- Calling the Montana Public Assistance Helpline at 1-888-706-1535
- Logging into your account at apply.mt.gov
- Faxing new information to 1-877-418-4533 or
- Mailing a letter to:
  DPHHS
  PO Box 202925
  Helena, MT 59620-2925

We are required to see if you still qualify for health coverage any time we find out about a change in your case. If you report a change and we find you no longer qualify for health coverage, we will send you a letter telling you your coverage will be ending and at what date. This letter will include information about other ways you may be able to get health coverage.

If you don't have any changes that affect your eligibility, your coverage will continue for a year.

REST OF LETTER REMOVED for review purposes (Fair Hearings, ETC)