<Insert date>
<Patient name>
<Insert patient address>

Dear parent or guardian of <Insert patient name>:

Our records show your child has not had the services marked below. These tests and screenings are recommended for your child. These services are available at no additional cost to you with your current Medicaid plan. It is important to take care of your child's health. Please call <insert name at physician office> at <Insert phone number> to schedule an appointment or if you have questions. Our office hours are <insert hours and days of operation>.

PREVENTION AND SCREENINGS
❑ Missing the <select one: 1, 2, 4, 6, 9, 12, 15, 18, 24> month(s) check up
❑ Yearly well care visit
❑ Yearly dental visit
❑ Blood lead screening at <Select one: 12, 24> months
❑ Missing the <select one or more: DTap, IPV, Hep B, MMR, HIB, VZV, PCV, MCV, Td, HPV> vaccine
❑ Yearly chlamydia screening for women 16 to 24 years old
MEDICATIONS
❑ Taking asthma medication as prescribed
❑ Taking behavioral health medication as prescribed
OTHER
❑ Yearly blood glucose or HbA1c and LDL-C or cholesterol test for anyone taking antipsychotic medication

Sincerely,

<Insert provider signature>

<Insert provider name>