

*Date*

*Requester Name  
Address  
City, State Zip Code*

RE: Request for Medicaid Records  
*Member Name*

Dear *Requester*:

This is in response to your request for Medicaid records of *Member Name* or *phrase this sentence to indicate this is in response to their request for their own records. This individual or you* has or have been identified in our Medicaid Member Information System (MMIS) database as eligible for Medicaid benefits from *Date Range of Eligibility*. Enclosed please find a certification of records.

Additionally, the Medicaid claims history records are being provided to you on a password protected /encrypted CD under separate cover by certified mail (*certified tracking number*). The password to unlock the documents is *Password*. Ordinarily, we would charge for providing this information. However, as a courtesy, we are providing this information to you free of charge.

If you have any questions, please feel free to contact me directly. I may be reached by telephone at (404) 657-7195 or by email at [pjohnson@dch.ga.gov](mailto:pjohnson@dch.ga.gov).

Sincerely,

Phyllis M. Johnson  
Office Manager  
Office of General Counsel

/pmj

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Enclosure