TEXAS
Health and Human
Services

Notice of Ineligibility

Applicant's Name	Date	Case No.
Applicant's Address (Street, City, State, ZIP Code)		
Provider Office Name		
Provider Office Address (Street, City, State, ZIP Code)	Provider Office Area Code and Phone No.	

Based on information received by this office, the following action is being taken. *(Only the checked box applies to you.)*

☐ Your application for the Primary Health Care Services Program, Title V Fee-for-Service Program or Epilepsy Program benefits has been denied because:

☐ You will not be eligible for the Primary Health Care Services Program, Title V Fee-for-Service Program or Epilepsy Program benefits after [mm/dd/yyyy] because:

If you believe this decision is not correct, you may appeal the decision by requesting a fair hearing. The request must be made in writing within 20 days of denial of eligibility. Contact the Texas Health and Human Services Commission (HHSC) at 800-222-3986 if you have any questions. Use the following extensions:

Primary Health Care Services Program x4385320
Title V FFS Program x4382574
Epilepsy Program x4383769