**[Date]**

|  |  |
| --- | --- |
| **[Participant]****[Address]** | **[Alternate Recipient (Child) or Designate Named in QMCSO]****[Address]** |

Dear **[participant]** and **[alternate recipient or designate]**:

This is to advise you that we have reviewed the **[court order]** or **[****National Medical Support** **Notice]** received on **[date]**, relating to the coverage of **[alternate recipient(s)]** under the **[enter name of group health plan(s)]** as a child **(children)** of **[participant]**. We have determined this **[court order]** or **[Notice]** is not a Qualified Medical Child Support Order (QMCSO) as defined under federal law.

***[Provide a listing of defective and/or missing provisions]***

***[Include one of the two alternative paragraphs below. The first paragraph is included if the child is not already enrolled as a dependent under the Plan. The second paragraph is included if the child is already enrolled as a dependent.]***

***[Alternate 1:]*** Because the **[court order]** or **[Notice]** does not meet the requirements of a QMCSO, **[alternate recipient(s)]** will not be provided coverage under the **[enter name of group health plan(s)]** at this time.

***[Alternate 2:]***Despite these defects, our records indicate that **[alternate recipient(s)]** is already enrolled as a dependent **[are already enrolled as dependents]** of **[participant]** under the terms of the **[enter name of group health plan(s)]**, and there will be no interruption in coverage as a result of the **[court order]** or **[Notice]**. Coverage for **[alternate recipients]** will continue only as long as otherwise provided under the terms of the plans listed above.

You have the right to submit written comments regarding this preliminary determination for a period of 30 days after the date of this letter. You should direct your comments to **[enter name of employer and contact]** at the following address, **[address]**. If no comments are received within this period, this determination will become final. If you do not intend to comment, please notify us of your intentions in writing. If comments are received during this period, the plan administrator (employer) will consider them and notify you of its final determination.

Please keep us informed of your current address during this period.

Sincerely,

**[Name]**

**[Title]**

**[Employer Name]**

**[Name of Plan/s]**

cc: **[Participant's Attorney, if any]**

**[Alternate Recipient's Attorney, if any]**

**[State Agency, if any]**