State of Hawaii
Department of Human Services

Med-QUEST Division

Medical Assistance Application: Need More Information
Ten-Day Pending Notice

Name _____ Today's Date _____

Address _____ Case Number _____

City, State, and Zip Code _____

We need more information to process your form. **Please return this paper with COPIES of items marked (☒) below.** Your medical assistance benefits may be denied or stopped if we do not receive them by the due date.

Due Date _____

You can mail, fax, or bring the **document copies** to the Med-QUEST office. If you need a free interpreter, have questions about this notice, or there is a problem with the document copies, please contact the eligibility worker listed below.

- ☐ U.S. Citizenship _____.
- ☐ Alien Status _____.
- ☐ Photo Identification _____.
- ☐ Income Statements _____.
- ☐ Asset Statements _____.
- ☐ Other Health Insurance Card _____.
- ☐ Unpaid Medical Bills or Estimate _____.
- ☐ Complete, Sign, and Return Forms _____.
- ☐ Social Security Number or Application for a Number _____.
- ☐ Other

Thank you for your cooperation and we look forward to helping you!

Authorization: H.A.R. 17-1705-7, 17-1705-10, 17-1711-6; 17-1711-7, 17-1711-9, 17-1711-12, 17-1711-13, 17-1713-4; _____.

Eligibility Worker Name _____ Phone Number _____