

Medicaid Managed Care/Family Health Plus Disenrollment Form

Applicant: Please print. Do not fill shaded areas. Reasons for leaving the Plan are on the back of this form.

Head of Household (Last Name, First, MI)	Case #	Name of Health Plan	County:
	S.S. #		LDSS/MCO Use Only:
Current Street Address Apt. #	City	State Zip Code	Phone # ()
			Emergency Phone # ()

Last Name	First Name	Date of Birth MM/DD/YY	Sex M/F	CIN Number	Social Security Number	Managed Care Plan Name	Reason for disenrollment SEE BACK FOR REASONS Check Box On Back & ENTER CODE Here	LDSS/ MCO use only

Shaded areas to be used by LDSS staff only

Status <input type="checkbox"/> Approved <input type="checkbox"/> Disapproved Projected disenrollment date: ____/____/____	New Plan Chosen <input type="checkbox"/> Yes Name of Plan: _____	End of Lock-in/Initial Enrollment Period: ____/____/____ (As Appropriate) <input type="checkbox"/> Check if Good Cause	New Enrollment Packet Sent <input type="checkbox"/> Yes Date: ____/____/____ <input type="checkbox"/> No
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I know that by filling out this form I may no longer get care from the Health Plan listed above. This means the doctors my family and I see now may not see us anymore. I will be notified when I am no longer in this Plan.

I also know that if I or any of my family members have joined this Health Plan less than 12 months ago, this disenrollment may not be approved unless I have a good reason to leave this Plan. I also know that if I live in an area where Medicaid managed care is mandatory, if I leave this Health Plan, I may have to join another Plan. If I need to be in a Health Plan to get health care, I will be told if I have to pick another Plan for me and my family.

Adult Signature(s): _____ Date ____/____/____

This form must be sent to your County Department of Social Services after you have filled it out.

REASONS FOR DISENROLLMENT

Instructions:

Check box and put code in space on front of form.

- 86 There is no doctor's office who can serve me in my language.
I am physically unable to get into the doctor's office.
- 86 My doctor is not in my plan.
- 86 I have to wait too long for an appointment with my doctor or specialist.
I have to wait too long in the doctor's office for my appointment.
- 86 I have difficulty getting in touch with the plan.
The plan has refused to give me the services that I think I need.
I do not like the staff at my doctor's office.
My doctor's office is not clean, unsafe, etc.
I do not like where my providers are located.
- 86 I have a hard time getting referrals or my plan has denied a referral for care.
- 86 I have a hard time getting family planning services.
- 86 My plan is no longer serving Medicaid recipients.
- 86 I do not like the rules of my health plan.
- 86 I do not like my plan and want to change during my grace period.
- 86 I do not like my plan and have a good reason to change during my lock-in period.
- 93 I am in a Medicaid category that is not **required** to be in managed care.
- 93 I am in a Medicaid category that is not **allowed** to be in managed care.
- 86 The plan representative was not clear about what I was signing up for.
I did not sign an enrollment form or tell anyone to sign for me.
- 97 I have moved and my plan has no services near my new home.

DSS Use Only

59 Lost Family Health Plus (FHPLUS) eligibility

95 Lost Medicaid (MA) eligibility

85 Death