

# 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)<br><br> | Case #<br><hr/> | Name of Health Plan<br><hr/> | County:<br><hr/>                  |
|  | S.S. #<br><hr/> |                              | LDSS/MCO Use Only:<br><hr/>       |
| Current Street Address      Apt. #<br><br>       | City<br><hr/>   | State      Zip Code<br><hr/> | Phone # (    )<br><hr/>           |
|  |                 |                              | Emergency Phone # (    )<br><hr/> |

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

Shaded areas to be used by LDSS staff only

|  |   |   |  |
|--|---|---|--|
| <b>Status</b><br><input type="checkbox"/> Approved<br><input type="checkbox"/> Disapproved<br>Projected disenrollment date: ____/____/____ | <b>New Plan Chosen</b><br><input type="checkbox"/> Yes<br>Name of Plan: _____ | <b>End of Lock-in/Initial<br/>Enrollment Period:</b> ____/____/____<br>(As Appropriate)<br><input type="checkbox"/> Check if Good Cause | <b>New Enrollment Packet Sent</b><br><input type="checkbox"/> Yes    Date: ____/____/____<br><input type="checkbox"/> No |
|--|---|---|--|

**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 (FHPPLUS) eligibility

95 Lost Medicaid (MA) eligibility

85 Death