Disenrollment Form

If you request disenrollment, you must continue to receive all medical care from your current HMO until the effective date of disenrollment. Contact us to verify your disenrollment before you seek medical services outside of HMO's network.

Last name:	First Name:	Middle Initial	□ Mr. □ Mrs. □ Miss □ Ms.
Medicaid #:			
Birth Date:	Sex: □ M □ F	Home Phone Number: ( ) ____ - _____	

Please sign and date this disenrollment form:

_____	_____	_____
Signature of recipient or the Responsible Party if under 18.*	Relationship to Child	Date

*****Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: 1) this person is authorized under State law to complete this disenrollment and 2) documentation of this authority is available upon request by First Health.

If you are the authorized representative, you must provide the following information:

Name: _____ **Phone Number:** (___) ____ -_____

Address: _____

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FOR OFFICIAL USE ONLY

APPROVAL TO CHANGE Vendor's

This form serves as notification that _____*Name of Recipient)* has requested disenrollment from _____*Name of Vendor)* for cause and that the Managed Care Organization (Vendor) has determined that the recipient has established good cause. The recipient will be disenrolled from his/her current Vendor and re-enrolled with the other contracted Vendor. The effective date of change in the Vendor will be based on the monthly administrative cut- off date but not later than the first day of the second month following the month in which the enrollee makes the request to disenroll. The recipient must continue to receive all medical care from your current Vendor until the effective date of disenrollment. A Notice of Decision will be sent to the recipient by the Vendor. The recipient will be locked into the other contracted Vendor until the next open enrollment period.

Reason for Disenrollment *(Circle Number)*:

1. The recipient moves out of the Vendor service area.
2. The plan does not, because of moral or religious objections, cover the service the recipient seeks.
3. The recipient needs related services (for example a cesarean section and a tubal ligation) to be performed at the same time; not all related services are available within the network; and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk.
4. Other reasons. (Explain) _____
5. DHCFP determination

Approved by Health Plan (signature of representative)_____

Date_____

Health Plan to fax form to the DHCFP, (775) 684-3774