Request To Disenroll From A Managed Care Health Plan Due To Serious Emotional Disturbance (SED)

Nevada Medicaid

Who must complete this form

In-network provider:

- This form must be completed by the member's in-network provider.
- If the provider is not part of the member's health plan network, the member should be directed to their current health plan for assistance.
- The consent section must be signed by the parent or legal guardian.

DCFS or County Staff:

- DCFS or County staff must complete this form when the child is in their custody, and they are requesting that the child remains in Fee-For-Service.

Parent or legal guardian:

- The parent or legal guardian may complete this form when they want the child to return to a health plan. The provider does not need to complete the form.

Serious Emotional Disturbance (SED) *is defined by someone under the* ***age of eighteen (18)*** *having (within the past year) a diagnosable mental, behavioral, or emotional disorder that resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.* (*https://www.samhsa.gov/mental-health/serious-mental-illness/about*)

Reasons to complete this form:

1. The member is currently enrolled in a health plan, and the **parent or legal guardian is requesting disenrollment** from the health plan based on SED determination. If approved, the member will transition to Fee-for-Service Medicaid coverage on the first day of the following month if submitted before the cut-off date, or on the first day of the second administrative month if submitted after the cut-off date.

2. This form is being submitted for the member's **annual SED re-determination** to continue to be covered under Fee-for-Service Medicaid.

3. The **Division of Child and Family Services (DCFS)** is requesting that the child remain covered under Fee-for-Service.

4. If the member is **no longer determined to have SED** or if the member's parent/legal guardian is requesting that the member **return to the MCO.** The provider does not need to complete the SED form. The parent/legal guardian completes the members' information, the consent information and then sends the request to the Managed Care email listed below.

Submission: Email the completed form to managedcare@nvha.nv.gov. Do not submit these instructions. **Incomplete forms will not be processed.**

Disclaimer: Under the State of Nevada Title XXI State Plan**, Nevada Check-Up** members are required to remain enrolled in Managed Care Organizations responsible for their ongoing care and cannot opt out. For more information, refer to Nevada Medicaid Services Manual Chapters 400, 2500, and 3600 (dhcfp.nv.gov/Resources/AdminSupport/Manuals/MSM/MSMHome/)

The most current SED form is available here: dhcfp.nv.gov/Members/BLU/MCOMain/.

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Nevada Medicaid

Member's Information (*Please print*)

Name:	Initial SED determination date:
DOB:	Annual re-determination date:
Medicaid ID:	Determination site:
Address:	☐ DCFS custody ☐ County custody

SED Determination (*Please check one*)

◯ YES, the child is determined to have a SED

◯ Child is **no longer** determined to have a SED. *The provider does not need to complete this form. See instructions above.*

This individual has been assessed in accordance with Nevada Medicaid's diagnostic criteria. For more details on the SED policy, please refer to the Medicaid Services Manual (MSM), Chapters 400, 2500, and 3600.

Provider/Assessor Information

Agency:	Date:	
Name of assessor:	Title:	
Signature:	Phone:	Fax:
Agency address:	Email:	

Are you enrolled with an MCO? ☐ Yes (check all that apply below). If the provider is **NOT** enrolled in the child's health plan **DO NOT COMPLETE THIS FORM.** Please direct the member to their current health plan for assistance.

- ☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions (844) 396-2329**
- ☐ **CareSource (833) 230-2058**
- ☐ **Health Plan of Nevada Medicaid, (800) 962-8074**
- ☐ **Molina Healthcare of Nevada, (833) 685-2102**
- ☐ **SilverSummit Healthplan (844) 366-2880**

Consent: (*To Be Completed by the Legally Responsible Individual*)

Print name of the responsible party:	Date:
*Signature of responsible party:	Phone:
Relationship to Member:	Email:

If the request is approved, the child will be cover under Fee-for-Service on the first day of the following month. Please check the box that applies:

1. **FIRST TIME SED determination, please check below:**
   ☐ I request that my child be disenrolled from a health plan and receive coverage through Fee-for-Service Medicaid.

2. **If the child is in the custody of DCFS or a County and this is their first SED determination, and DCFS requests continued Fee-for-Service Medicaid coverage, please check below:**
   ☐ Request to remain in Fee-for-Service.

3. **Annual SED Re-Determination, pick one:**
   ◯ I want my child to remain Fee-for-Service.
   ◯ I want my child to return to a health plan.

4. The member will be assigned to the current household health plan or the health plan they were previously enrolled in. **If no household members are in a health plan, pick one:**
   ◯ **Anthem Blue Cross and Blue Shield Healthcare Solutions, (844) 396-2329**
   ◯ **CareSource, (833) 230-2058**
   ◯ **Health Plan of Nevada Medicaid, (800) 962-8074**
   ◯ **Molina Healthcare of Nevada, (833) 685-2102**
   ◯ **SilverSummit HealthPlan, (844) 366-2880**

Print member's name:	Member's Medicaid ID:
*Signature of responsible party:	Date:

**This form can be signed by the member's parent, legal guardian, or an individual who is legally authorized to act on the member's behalf under the laws of the state where the member resides. By signing, the individual certifies that:*

1. *They are authorized under state law to complete this disenrollment or enrollment change.*
2. *Documentation confirming this authorization is available upon request.*

Please email the completed form to managedcare@nvha.nv.gov. Do not submit instructions.

If you have questions, call Nevada Medicaid (866) 569-1746 (TTY: 7-1-1), or email medicaid@nvha.nv.gov.