NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY SEVERELY EMOTIONALLY DISTURBED (SED) CHILDREN MANAGED CARE ORGANIZATION (MCO) DISENROLLMENT FORM

To stay current with policy and documentation updates, we recommend that you visit https://dhcfp.nv.gov/ frequently.

You can find the SED MCO Disenrollment Form and these instructions on the Managed Care webpage at https://dhcfp.nv.gov/Members/BLU/MCOMain/ under Links & Resources.

Instructions for completing this form:

The first page of this form must be completed by the MCO or one of its in-network providers and submitted to DHCFP or its designee within five business days after the SED Determination. If this page is not completed by the MCO or an in-network provider, it will be discarded.

Reasons to complete this form:

1. The recipient is enrolled in an MCO and is requesting disenrollment from the MCO due to an SED determination and be covered under fee for service (FFS).
2. This is the recipient's annual SED re-determination.
3. The recipient is no longer determined SED or wishes to return to an MCO.

Email the completed form to managedcare@dhcfp.nv.gov or fax it to DHCFP Managed Care & Quality Assurance Unit: (775) 684-3774. (*Instructions do not need to be faxed*).

Disclaimer:
Pursuant to the State of Nevada Title XXI State Plan, ***Nevada Check Up recipients*** *must remain enrolled with the managed care organization that is responsible for on-going patient care.*

Recipient Information (Please Print)

1. Name – Enter the recipient's name as it appears on their Medicaid card.
2. DOB – Enter the recipient's date of birth(DOB).
3. Medicaid ID – Enter 11-digit number shown on the front of the recipient's Medicaid card.
4. Address – Enter recipient's home address.
5. Original SED determination date – If this is an original SED determination, check this box and enter the determination date.
6. Annual re-determination date - If this is an annual re-determination, check this box and enter the SED re-determination date.
7. Determination site - Enter the place where the SED determination was conducted.
8. DCFS custody - County custody – Check if the child is in DCFS custody or County custody.

SED Determination (*please check one*)

1. YES, child determined SED - Check this box if this is the original determination and the child is determined SED.
2. Child remains SED - Check this box if this is the annual re-determination and the child remains SED.
3. Child no longer SED - Check this box if the child is no longer SED. Child will be assigned to an MCO.

Provider/Assessor Information

1. Agency – Enter the name of the agency you are authorizing to conduct the assessment and share the results with DHCFP. By filling out this section of the form, you attest that the named agency has fully explained the reason why the child requires an assessment at this time.
2. Name of assessor – Enter the name of the assessor.
3. Signature – assessor's signature.
4. Agency address – Enter the address of the agency (including City, State and Zip Code).
5. Date – Enter the date the form was completed.
6. Title - Enter the title of the assessor.
7. Phone/Fax - Enter the assessors phone number and fax number.

Provider Current MCO Enrollment

1. The provider needs to check the MCO they are credentialed with. *(check all that apply)*

SED CONSENT: T*o be completed by the legally responsible individual*)

1. Print Name of recipient – Print the recipient's name as it appears on their Medicaid card.
2. Print Name of responsible party – Print the name of the person legally responsible for the child (i.e. parent or guardian).
3. Signature of responsible party – Signature of the responsible party is required.
4. Address – Enter responsible party address (including City, State and Zip Code).
5. Relationship to recipient – Enter the responsible party's relationship to the recipient.
6. Date – Enter the date the form was signed by the responsible party.
7. Phone– Enter the responsible party's phone number. If the responsible party does not have a phone number, enter "N/A" in this field.
8. Fax – Enter fax number if any.

MCO Disenrollment request due to SED Determination

1. Check this box if this is the recipient's first SED determination and they are requesting to be disenrolled from their current MCO to be covered under Fee-for-Service.
2. If this is an annual re-determination or the recipient was previously disenrolled from their MCO due to an SED determination, please check one of the options:

    - Check if the recipient wishes to remain in Fee-for-Service Medicaid.
    - Check if the recipient wishes to disenroll from their MCO and be covered under Fee-for-Service Medicaid.
    - Check if the recipient wishes to return to managed care.
    - The recipient will be assigned to the current household MCO. If there are no household members currently enrolled in an MCO, indicate the recipient's choice below (choose only one).
3. Print name of recipient - Enter the recipient's name as it appears on their Medicaid card.
4. Signature of responsible party – Signature of responsible party is required.
5. Recipient's Medicaid Id - Enter recipient's Medicaid Id.
6. Date – Enter the date the form was signed by the responsible party.

Note to Provider: Verify the recipient's address and phone number are current. If the recipient has moved, remind them to update their address and phone number with the Division of Welfare and Supportive Services (DWSS) by visiting one of the links below or by calling their local Welfare office.

- **Southern Nevada: (702) 486-1646**
  https://dwss.nv.gov/Contact/Welfare_District_Offices-South/
- **Northern Nevada: (775) 684-7200**
  https://dwss.nv.gov/Contact/Welfare_District_Offices-North/ **or Toll Free: 1(800) 992-0900 or TTY 7-1-1**
- Log into the Access NV web portal to update your address at https://accessnevada.dwss.nv.gov/public/landing-page.
- Recipients may also submit an address change at the following link: https://dhcfp.nv.gov/UpdateMyaddress/.

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Recipient Information (*Please print*)

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

SED Determination (*Please check one)*

- ◯ YES, child determined SED
- ◯ Child remains SED
- ◯ Child **no longer** SED

This individual has been assessed according to the Nevada Division of Health Care Financing and Policy (DHCFP) diagnostic criteria. (For more information about SED determinations, see Medicaid Services Manual (MSM) Chapter 400).

Provider/Assessor Information

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

Provider Current MCO Enrollment: (*check all that apply*)

- ☐ **Anthem Blue Cross and Blue Shield Healthcare Solutions, (844) 396-2329**
- ☐ **Health Plan of Nevada, (800) 962-8074**
- ☐ **Molina Healthcare of Nevada, (833) 685-2109**
- ☐ **SilverSummit HealthPlan, (844) 366-2880**

SED Consent (*to be completed by the legally responsible individual)*

Print name of recipient:	Relationship to recipient:
Print name of responsible party:	Date:

Signature of Responsible Party*:	Phone:
Address:	Fax:

MCO Disenrollment request due to SED Determination

This form serves as an account of the recipient's wishes in regard to their Medicaid managed care enrollment. If disenrollment is requested and approved the disenrollment will commence the first day of the next administrative month and all covered medically necessary services, including, but not limited to, services specific to the recipient's SED diagnosis, will be authorized and reimbursed through Fee-for-Service Medicaid. If no disenrollment is requested, the recipient will continue to receive services through their MCO.

1. **If this is the recipient's first SED determination, *please check below*:**

   ☐ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.

2. **If this is the recipient's annual re-determination or they were previously disenrolled from managed care due to an SED determination, please indicate the recipient's choice below (*choose only one*):**

   ◯ I wish to remain Fee-for-Service Medicaid.
   ◯ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.
   ◯ I wish to return to managed care and be enrolled in an MCO.

The recipient will be assigned to the current household MCO. If there are no household members currently enrolled in an MCO, indicate the recipient's choice below (*choose only one*).

◯ Anthem Blue Cross and Blue Shield Healthcare Solutions, (844) 396-2329
◯ Health Plan of Nevada
◯ Molina Healthcare of Nevada
◯ SilverSummit Healthplan

Print name of recipient:	Recipient Medicaid ID:
Signature of responsible party*:	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.

You may email the completed form to Managedcaresupport@dhcfp.nv.gov or you may fax it to the DHCFP Managed Care & Quality Assurance unit at (775) 684-3774**. *If any information is missing this form will be discarded*.**

For the complete policy regarding SED disenrollment from managed care, refer to MSM Chapter 3600, which is available on the DHCFP website at http://dhcfp.nv.gov/.