

Voluntary Disenrollment Form

Program Name _____ Phone Number _____

Program Contact Person _____

Program Address _____

Client's Name _____ Medicaid Number _____

Client's Address _____

Representative's Name _____ Representative's Phone Number _____

Representative's Address _____

Date of enrollment _____

Date of disenrollment _____

Reason for disenrollment

- The member has moved out of the contractor's service area.
- The contractor does not (due to moral or religious objections) cover the service the member seeks.
- Poor quality of care.
- Lack of access to covered services, or lack of access to providers experienced with member's needs.
- The member needs related services to be performed at the same time, not all related services are available within the provider network and the member's primary care provider (or another provider) determines that receiving the services separately would subject them to unnecessary risk.
- The member becomes emancipated, is added to a different Medicaid case, or the MCO changes it's network of providers which interferes with the continuity of care with the member's provider.

Summary

The client has chosen to voluntarily disenroll

Client's Signature _____ Date _____

Representative's Signature _____ Date _____

Completed by _____ Date _____

Phone Number _____