Health Plan-Initiated Disenrollment Request Form

Healthy Connections CHOICES
South Carolina Healthy Connections Choices
P.O. Box 8691
Columbia, SC 29202-9255
Ph: 1-877-552-4642 TTY/TDD Line: 1-877-552-4670

Please complete and submit one form per member. Also include required documentation.

- Mail to: P.O. Box 8691, Columbia, SC 29202-9255
- Or fax to: 1-877-552-4672

Name of health plan: _____

Member Information:

- Name of member to be disenrolled: _____ (Last) _____ (First) _____ (Middle Initial)
- Birth date: / /_____
- Medicaid ID: _____
- Home address: _____
  _____
- Home phone: ( ) _____
  County: _____
  Requested disenrollment date: / /

Reason for Request: Check the box that applies. Documentation must be submitted for any reason marked with an asterisk. Lack of sufficient documentation may result in denial.

- ☐ *Member has Medicare coverage
- ☐ Member has elected hospice
- ☐ Member has elected a home- and community-based waiver program
- ☐ *Member has been in a long-term care facility or a nursing home for more than 90 calendar days
- ☐ *Member is placed out of home, e.g., Intermediate Care Facility for the Mentally Retarded (ICF/MR) or Psychiatric Residential Treatment Facility (PRTF)
- ☐ *Member is an inmate of a public institution
- ☐ *Member moved out of state or the health plan's service area
- ☐ *Member's behavior is disruptive, unruly, abusive, or uncooperative and impairs the health plan's ability to furnish services to the member or other members
- ☐ *Member has died
- ☐ *Other (please explain): _____

_____

_____

_____

Authorized signature: _____ Date: _____/_____/_____

Print name: _____

South Carolina Healthy Connections Statement:

The health plan shall not discriminate against any South Carolina Healthy Connections member on the basis of their health status, need for health care services, or any other adverse reason with regard to the member's health, race, sex, handicap, age, religion, or national origin.

The South Carolina Department of Health and Human Services (SCDHHS) will determine if the health plan has shown good cause to disenroll the above-named member. All decisions will be reflected on the monthly 834 file. Members have the right to appeal enrollment and disenrollment decisions with SCDHHS.