FIDA Plan
INVOLUNTARY DISENROLLMENT REQUEST FORM

0000000000BQ

Please Print

Plan Name: _____

Nurse/Case Manager: _____

Signature: _____

Telephone

(Area Code)

Member's Name: _____

Medicaid Number: ___ ___ ___ ___ ___ ___ ___ ___ Medicare Number: ___ ___ ___ -___ ___-___ ___ ___ ___ -___ ___

Plan must select ☑ the disenrollment reason for this request and provide the required supporting documentation.

Involuntary Disenrollment Reason	Required Supporting Documentation
☐ Enrollee did not complete Medicaid recertification and plan policy does not allow continued coverage while recertification process is completed.	Written statement from Health Plan (on Plan letterhead) describing the case situation.
☐ Enrollee is no longer a New York State resident.	Evidence of consumer's new residence. Plan must provide dates of when HRA/LDSS was notified of the new address.
☐ Enrollee no longer lives in the plan's service area.	Evidence of consumer's new residence. Plan must provide dates of when HRA/LDSS was notified of the new address.
☐ Residing out of the plan service area for more than 6 consecutive months.	Statement from Plan, or other pertinent evidence, that an effort was made to contact the enrollee. Date of last contact with consumer: ___ ___ /___ ___/ ___ ___ ___ ___
☐ Enrollee no longer requires long term care services.	Long Term Care Uniform Assessment System for New York (UAS-NY) index and score.
☐ Enrollee is a resident of an alcohol or substance abuse program.	Name of Program: _____ Date of admission: ___ ___ /___ ___/ ___ ___ ___ ___
☐ Enrollee receives OPWDD services.	Name of Program: _____ Date of admission: ___ ___ /___ ___/ ___ ___ ___ ___

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FIDA Plan
INVOLUNTARY DISENROLLMENT REQUEST FORM *Continued*

Please Print

Plan Name: _____

Member's Name: _____

Medicaid Number: ___ ___ ___ ___ ___ ___ ___ ___ Medicare Number: ___ ___ ___ -___ ___-___ ___ ___ ___ -___ ___

Involuntary Disenrollment Reason	Required Supporting Documentation
❑ Enrollee is a resident of an OMH.	Name of Program: _____ Date of admission: ___ ___ /___ ___/ ___ ___ ___ ___
❑ Enrollee is deceased.	Written statement from Health Plan (on Plan letterhead) describing the case situation.
❑ Enrollee is incarcerated.	Written statement from Health Plan (on Plan letterhead) describing the case situation.