MCO Request for Member Disenrollment

To: Medicaid MCO Enrollment Broker MAXIMUS FAX: 1-888-858-3875

From: MCO MCO FAX: 866-768-9374

Print the Name of Member (Last, First, Middle Initial)	Birth Date	Medicaid ID Number or Social Security Number

☐ Member has demonstrated a pattern of disruptive, unruly, abusive or uncooperative behavior to the extent that enrollment in the MCO seriously impairs the organization's ability to furnish services to either the member or other members **and** the member's behavior is not caused by a physical or mental condition. (Attach separate narrative with additional information including measures taken by the MCO to correct the member's behavior prior to submitting the request for disenrollment)

☐ Member's utilization of services is fraudulent or abusive (e.g. member loans the MCO issued ID card to another person to obtain services). (Attach narrative with additional information including date of referral to Medicaid Program Integrity's Fraud Hotline)

☐ Member is placed in a long-term care nursing facility, ICF/DD facility, or becomes eligible for a Medicaid Home and Community-Based Services Waiver. Indicate which _____

☐ Member expired Date: _____

☐Member incarcerated Date:_____ Facility:_____

☐ Member has moved out of state. New Address: _____

☐ Other _____

Health Plan Signature:_____**Date:** _____

The Louisiana Department of Health and Hospitals will determine if the MCO has shown a good cause to disenroll the Medicaid/CHIP member. The Enrollment Broker will give written notification to the MCO of the decision. Medicaid/CHIP members have the right to appeal disenrollment decisions and request a state fair hearing with the Division of Administrative Law. All requests will be reviewed on a case-by-case basis and are subject to the sole discretion of DHH or its designee (Enrollment Broker). All decisions are final and not subject to the dispute resolution process by the MCO.

The MCO shall not discriminate against any Medicaid /CHIP 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.

☐**Disenrollment Approved Effective Date: _____** ☐**Disenrollment Denied/Reason:**_____

DHH Signature:_____**Date:** _____

Maximus Signature:_____**Date**: _____

Health Plan notified of decision.