Medicaid Health Plan Change Request Form

Medicaid managed care members can change health plans without cause during the ninety (90) days following the date of initial enrollment in a health plan. A member may request to change plans without cause at least once every twelve (12) months during Medicaid's annual Open Enrollment. A member may request to change plans for "good cause" (as determined by EOHHS on an individual basis) at any time (*42 CFR 438.56(d)(2)).* You may be able to change plans if*:*

- *You move out of your health plan's service area.*
- *Your health plan does not cover the service you seek, because of moral or religious objections.*
- *Your provider has said that some of the medical services you need must be received at the same time and all the services aren't available within your health plan*
- *You receive long term services and supports (LTSS), and you would have to change your residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider*
- *Other reasons, including poor quality of care, lack of access to* services *covered under the contract, or lack of access to providers experienced in dealing with your care needs.*

The State will also consider plan change requests if the member's provider no longer participates in the member's health plan.

Important things to know before requesting to change your health plan:

- All three (3) health plans offer the same benefit package.
- Be sure all of your family's providers are participating in the new plan before you request to change plans.
- EOHHS will make the final determination to approve or deny your request to change health plans.
- If you change plans, and your family is enrolled in RIte Care, your entire family must change as well.
- If you are receiving care that requires an authorization, you and/or your provider will need to speak with your new health plan about getting a new authorization.
- Changes can take up to 8 weeks to process. Your new health plan will notify you of your actual enrollment date.

1. Head of Household/Individual information:

Last Name	First Name	Middle Initial	Social Security number
Address	**Street**	**Apartment number**	**Phone**
City/Town	**State**	**Zip Code**	

2. Other members in your household:

Last Name	First Name	Middle Initial	Social Security number

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3. Please check which health plan you and/or your family currently have.

□ Neighborhood Health Plan of RI	□ Tufts Health Plan RITogether	□ UnitedHealthcare Community Plan

4. Please tell us why you want to disenroll from your current managed care health plan?

_____

_____

_____

5. Is this request to change health plans urgent (for example, an urgent medical/behavioral health situation or unusual circumstance that requires a quick response)? □ Yes □ No

If YES, please explain: _____

_____

6. Please check the health plan you and/or your family would like to be enrolled in:

□ Neighborhood Health Plan of RI (800) 459-6019	□ Tufts Health Plan RITogether (866) 738-4116	□ United Healthcare Community Plan (800) 587-5187

If you are enrolled in the Communities of Care or the Pharmacy Home programs, you will continue to be enrolled in that program(s) even if you change your health plan. By choosing a new Managed Care Health Plan, you are authorizing your current Health Plan to release necessary medical information to your new Health Plan. This will help your new Health Plan provide you with the best care possible.

7. Member please sign below:

_____ _____

Head of Household/Individual Signature Date

Please complete this form and mail it to:
RI Executive Office of Health & Human Services
Enrollment Unit
3 West Road
Cranston, RI 02920