

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance



REQUEST FOR DISENROLLMENT OF DC MEDICAID MANAGED CARE
BENEFICIARY REQUIRING LONG TERM CARE

Member's Name: _____

Member's Date of Birth: _____

Member's Medicaid Number: _____

Member's Social Security Number: _____

Current Health Plan: _____

Member's Diagnosis: _____

Name, Address, and Phone Number of Treating Facility: _____

Date of Admission: _____

Anticipated Length of Stay: _____

Reason for Disenrollment Request: _____

Proposed Effective Date of Disenrollment: _____

SSI Filing Date, if Applicable: _____

Submitted By _____

(Print Name)

(Date of Request)

Organization

Phone Number

Fax Number

FAX FORM TO MANAGEMENT ANALYST, DIVISION OF MANAGED CARE
FAX NO. (202) 610-3209