State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

HEALTHCHOICE DISENROLLMENT FORM (LONG TERM CARE)

Recipient M.A. ID:	Social Security Number:	DOB: Month/Day/Year
Last Name:	First Name:	M.I. Sex: Female
MCO Provider Name: UnitedHealth	MCO Provider No:	

Long Term Care Facility Information:

Name: _____

Address: _____

Telephone Number: _____

Admission Date: _____

Anticipated Discharge Date, if any: _____

MCO Official Representative: _____ Date: _____

Title: _____ Phone: _____

Disenrollment Date: _____

(to be determined by Department)

Please attach the Utilization Control Agent (Delmarva Foundation) certification of medical eligibility for LTC services (from the DHMH 3871)

Send or fax to:

HealthChoice Long Term Care
Disenrollment Unit
DHMH
201 W. Preston St., Rm L-9
Baltimore, MD 21201
Phone: 410-767-5321
Fax: 410-333-7141

DHMH INTERNAL USE ONLY

Completed by DHMH: _____

Initials: _____

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