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

DATE OF DIAGNOSIS: ____________________ **STATE ID:** ______________________________

SPECIAL CAPITATION ENROLLEE

Notification from MCO of AIDS Defined Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as having **AIDS**:

____ Effective Date of Enrollment: ____________________
MCO

Name: ____
Last First MI

Address: ____
Street Apt.

____
City State Zip

Resident County: ____________________ Medical Assistance Number: ____________________

Birth Date: ____________________ Gender: M ☐ F ☐

Race: (check all that apply) ☐ White ☐ African American ☐ Hispanic ☐ Asian/Pacific Islander
☐ Native American/American Indian ☐ Other: (define) ____________________

Social Security Number: ______________________________

PCP: ______________________________ Phone Number of PCP: ____________________

Signature of MCO Medical Director: ____________________ Date: ____________________

Please mail or hand carry this completed form to:

DHMH HealthChoice Enrollment Unit, 201 W. Preston Street, Room L-9, Baltimore, MD 21201
Attention: Rosemary Vranish

TO BE COMPLETED BY DHMH:

Diagnosis Verified: ____________________ *Date Received by DHMH:* ____________

Temporary Span: ____________________

Confirmed Spans: ____________________ *Date Received by IDEHA/CHSE:* ____________

Rev: 6/1/11