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 HIV Positive Enrollee

On the basis of the best available medical evidence, the following member has been diagnosed as being **HIV+**

United HealthCare ▼ Effective Date of Enrollment: _____

MCO

Name: _____

Last First MI

Address: _____

Street Apt.

WY ▼

City State Zip

Resident County: Worcester ▼ 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: _____

Date submitted by MCO: _____

Please mail results of laboratory testing to support verification to:

IDEHA/CHSE, 500 North Calvert Street, 5th Floor, Baltimore, MD 21202
Attention: MCO Coordinator

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:* _____

Confirmed Spans: _____ *Date Received by IDEHA/CHSE:* _____

Rev: 6/1/11