MARYLAND Department of Health

Maryland Department of Health
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:
MCO Provider Name:		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 certification of medical eligibility for LTC services (from the DHMH 3871).

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

MDH INTERNAL USE ONLY

Completed by MDH: ______________

Initials: ______________

Rev. 9/25/2017