Request for Disenrollment

Completed form must be submitted via fax to 1-888-858-3875. All supporting information must be included and documentation may be attached.

Date of Request	

Member Data					
First Name		Last Name		Date of Birth	
Social Security Number		Medicaid ID			

Who is requesting the disenrollment, and why? Select one.		
Requestor:		**For Cause Reason:**
	Member or Authorized Representative	
	MCO	
	LDH or designee	

Current MCO		Requested MCO	

Please add information to support the request, including dates.

Who completed this form?			
Name		Phone Number	

Revised 11/17/17

LOUISIANA
DEPARTMENT OF HEALTH
Medicaid

FOR MCO USE ONLY					
Receipt Date:					
Recommendation:	☐ Approve	☐ Deny	Date:		
Supporting Information:					
Contact Name:		Contact Number:			

FOR LDH USE ONLY					
Receipt Date:					
Final Decision:	☐ Approve	☐ Deny	Date:		
Supporting Information:	If approved, the effective date of disenrollment shall be:				
Contact Name:		Contact Number:			