



Provider Request for Member Disenrollment

Provider: Please complete the following sections, including the program you are participating in as a Primary Care Case Manager (PCCM). After a request for disenrollment is submitted, the member is notified and allowed five days to respond. If the member does not make another selection and your request is approved, the disenrollment is processed. You must continue to provide care to the member or refer the member for care until the disenrollment is effective.

General Disenrollment Guidelines: Members may be disenrolled due to office policy; however, the office policy must apply to all patients in the provider's practice. Disenrollments must be based on behavioral and not monetary issues.

Send request to: **IME Provider Services Unit**
P.O. Box 36450
Des Moines, IA 50315

Or fax to 515-725-1155

Part A: Provider Information (Please complete the following information.)

Check type of managed care that applies: PCCM for MediPASS PCCM for Wellness

Provider Name		Provider ID/National Provider Identifier	
Street Address			
City		State	Zip Code
Provider Signature			Date

Part B: Disenrollment Request (Please complete the information below for each person for whom disenrollment is requested.)

Member Name	Medicaid Person ID (from Medicaid card)	Disenrollment Code (see right)	Disenrollment Reason Code (attach documentation)
			A. Continuously fails appointments
			B. Abusive behavior with office staff
			C. Seeks unauthorized care from others
			D. Drug seeking behavior
			E. Non-compliance with treatment regime
			F. Doesn't serve client's age/sex
			G. Other (please describe) _____

Part C: Managed Health Care Review Committee Decision (Central office use only.)

<input type="checkbox"/> Approved <input type="checkbox"/> Denied <input type="checkbox"/> Other _____		Member Contact Date:
Comments		
Date Processed	Signature	

NOTE: A copy of this request will be kept on file.