Medicaid Health Plan Change Request Form

Medicaid managed care members can change health plans without cause during the ninety (90) days following the date of initial enrollment in a health plan. A member may request to change plans without cause at least once every twelve (12) months during Medicaid's annual Open Enrollment. A member may request to change plans for "good cause" (as determined by EOHHS on an individual basis) at any time (*42 CFR 438.56(d)(2)).* You may be able to change plans if*:*

1. *You move out of your health plan's service area.*
2. *Your health plan does not cover the service you seek because of moral or religious objections.*
3. *Your provider has said that some of the medical services you need must be received at the same time and all the services aren't available within your health plan.*
4. *You receive long term services and supports (LTSS), and you would have to change your residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider.*
5. *Other reasons, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with your care needs.*

The Executive Office of Health & Human Services (EOHHS) will also consider plan change requests if the member's provider no longer participates in the member's health plan.

Important things to know before requesting to change your health plan:

- All three (3) health plans offer the same benefit package.
- Be sure all of your family's providers are participating in the new plan before you request to change plans.
- **EOHHS will make the final determination to approve or deny your request to change health plans.**
- If you change plans, and your family is enrolled in RIte Care, your entire family must change as well.
- If you are receiving care that requires an authorization, you and/or your provider will need to speak with your new health plan about getting a new authorization.
- Changes can take up to eight (8) weeks to process. Your new health plan will notify you of your new enrollment date if approved by EOHHS.

Please send the completed form by mail to:
RI Executive Office of Health & Human Services
Enrollment Unit
3 West Road
Cranston, RI 02920
Please add "secure" to email the completed form to ohhs.memberenrollment@ohhs.ri.gov

DHS Non-Discrimination Policy

In accordance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. 794), Americans with Disabilities Act of 1990 (42 U.S.C. 12101 et seq.), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Food Stamp Act, and the Age Discrimination Act of 1975, the U.S. Department of Health and Human Services implementing regulations (45 C.F.R. Parts 80 and 84), the U.S. Department of Education implementing regulations (34 C.F.R. Parts 104 and 106), and the U.S. Department of Agriculture, Food and Nutrition Services (7 C.F.R. 272.6), the Rhode Island Department of Human Services (DHS), does not discriminate on the basis of race, color, national origin, disability, political beliefs, age, religion or sex in acceptance for or provision of services, employment or treatment, in its educational and other programs and activities. Under other provisions of applicable law, DHS does not discriminate on the basis of sexual orientation.

For further information about these laws, regulations and DHS' discrimination complaint procedures for resolution of complaints of discrimination, contact DHS at 57 Howard Avenue, Cranston, RI 02920, telephone number 462-2130 (TDD 462-6239 or 711). The Community Relations Liaison Officer is the coordinator for implementation of Title VI; the Office of Rehabilitation Services (ORS) Administrator or his/her designee is the coordinator for implementation of Title IX, Section 504, and ADA. The Director of DHS or his/her designee has the overall responsibility for DHS' civil rights compliance.

Medicaid Health Plan Change Request Form

Directions: Please complete all information. Missing or incomplete requests may not be reviewed by EOHHS.

1. Head of Household/Individual information:

Last Name	First Name	Middle Initial	Social Security Number
Address		Apt/Unit #	Phone Number
City/Town		State	Zip Code

2. Other members in your household:

(If there are additional members to be listed, please enter in text box #4.)

Last Name	First Name	Middle Initial	Social Security Number
Last Name	First Name	Middle Initial	Social Security Number
Last Name	First Name	Middle Initial	Social Security Number
Last Name	First Name	Middle Initial	Social Security Number

3. Please check which health plan you and/or your family ***currently*** have.

◯ Neighborhood Health Plan of RI	◯ Tufts Health Plan RITogether	◯ UnitedHealthcare Community Plan

4. Please tell us why you want to change from your current managed care health plan? Provide details such as health care provider name(s), prescriptions in question or other details to help describe why you want to change from your current managed care health plan. Please provide as much detail as possible.

Is this request to change health plans urgent (for example, an urgent medical/behavioral health situation or unusual circumstance that requires a quick response)? Please check yes or no if this request is urgent.

◯ Yes ◯ No

5. Please check the health plan you and/or your family would like to be enrolled in:

◯ Neighborhood Health Plan of RI (800) 459-6019	◯ Tufts Health Plan RITogether (866) 738-4116	◯ United Healthcare Community Plan (800) 587-5187

If you are enrolled in the Communities of Care or the Pharmacy Home programs, you will continue to be enrolled in that program(s) even if you change your health plan. By choosing a new Managed Care Health Plan, you are authorizing your current Health Plan to release necessary medical information to your new Health Plan. This will help your new Health Plan provide you with the best care possible.

6. Member's signature:

_____ _____

Head of Household/Individual Signature Date