



Medicaid Managed Care Reenrollment Member Request Form

This form is for RI Medicaid members who have been terminated from Medicaid and would like to request to be reenrolled in their prior health plan. To qualify for this request, you must have submitted your renewal packet to RI DHS and this request form within one (1) month of termination **AND** have an extenuating circumstance. All reenrollment requests are dependent upon the member being eligible for Medicaid. To request reenrollment, please complete the following form and email it to ohhs.enrollment@ohhs.ri.gov.

1	Full Name	
2	Medicaid ID	
3	Mailing Address (Street Number, Street, Town, State, Zip Code)	
4	Phone Number	
5	Email Address	
6	Have you submitted your renewal packet?	Yes No
<p style="color: red; text-align: center;">If you have not submitted your renewal packet, you must do so before proceeding and before being considered for reenrollment in your health plan. For assistance, please contact RI DHS at the DHS Info Line: 855-697-4347 or the DHS Director's Line/Constituent Line: 401- 462-2121.</p>		
7	If yes, what date did you submit your renewal packet?	
8	If yes, how did you submit your renewal packet?	Mail Online portal In-person drop off If in-person, which location? Other
9	Most Recent Managed Care Organization Enrollment	Tufts Health Plan United Healthcare Neighborhood Health Plan of Rhode Island
10	Date of Medicaid Termination	
11	Reason for Reenrollment Request (select all that apply)	You are in ongoing, urgent, and current treatment Your provider only accepts managed care coverage and not fee-for-service Managed care plan is the only plan that covers required services (services are not available in fee-for-service) Managed care plan is the only plan that covers required, prescribed medications (e.g., covers brand name medication) You have an extenuating reason why you could not submit paperwork on time for redetermination (e.g., you were in the hospital for an extended stay, you received a renewal packet in the wrong language, you are experiencing homelessness and did not have a permanent address, etc.)
12	Please describe your circumstance that requires reenrollment in your previous managed care plan.	