



PLEASE FAX
TO 904-244-9409

MEMBER DISENROLLMENT

(ALL FIELDS MUST BE COMPLETED BEFORE DISENROLLMENT / TRANSFER OCCURS)

Today's Date: _____

Members Last Name: _____ Members First Name: _____

Date of Birth: _____ Medicaid ID Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Member Home Phone: _____ Member Alternate Phone: _____

Reason for Disenrollment (Select One):

- Member moved out of the FCA service area:

New address: _____

- Member death (Date of expiration _____)

- Member ineligible for plan enrollment (Reason _____)

- Hospice (Date of Admission _____)

- Skilled Nursing/Nursing Home/TCU

- FACT Team Member

- Other _____

For a complete list of Ineligible Populations please see Page 2 of the FCA Disenrollment Process found on the FCA website under the Provider button

- Other Insurance is Primary

Third Party Insurance Company Name: _____

Third Party Insurance Phone Number: _____

Third Party Insurance Policy Number: _____

Policy Holder's Name: _____

Coverage Effective Date: _____

(Please include proof of other insurance – Medifax or copy of ID card)

Person who is completing this form: _____

Phone number: _____ Date completed: _____

Email address: _____

Clinic or Office Location: _____

FOR FCA OFFICE USE ONLY:

Date added to AHCA disenrollment Report: _____

Disenrolled as of: _____

Date disenrollment letter sent to Member: _____