SPECIAL DISENROLLMENT – FOR CAUSE REQUEST

Michigan Department of Health and Human Services

SECTION I (To be Completed by the Beneficiary or Authorized Representative)

Beneficiary Name	Beneficiary Telephone Number	
Beneficiary Medicaid ID Number	Beneficiary Case Number (Optional)	
Beneficiary Address (Number and Street)	Beneficiary Date of Birth	
City	State MI	Zip

Beneficiary Signature		Date
Authorized Representative Legal Guardian Name	Telephone Number	Relationship to Beneficiary
Signature of Authorized Representative or Legal Guardian		Date

Name of Current Plan	Name of Plan You Want

Reason for Request:

☐=Concerns with Quality of Care
☐=Lack of Access to Covered Services or Providers Experienced in Dealing with Health / Dental Needs
☐=Lack of Primary Care within 30 Miles/Minutes from where you live
☐=Medical

Describe why you are asking for the change in plans, what actions you have taken to work with your plan, and why your plan is not able to provide your care or services (attach additional pages if needed).

SECTION II (TO BE COMPLETED BY BENEFICIARY'S TREATING PROVIDER)

Provider Name (please print)	Provider Specialty	NPI Number
Provider Office Address	Telephone Number	Office Contact Person

Describe why a change in plans is needed and what has been done to work with the current plan to resolve issue(s) before asking for this review (attach additional pages if needed).

Provider Signature	**Date Signed**

SPECIAL DISENROLLMENT – FOR CAUSE REQUEST
Instructions

Please complete this form if Michigan Enrolls cannot change your health plan and you want the Michigan Department of Health and Human Services (MDHHS) to consider a change from one plan to another plan "For Cause" outside of your yearly open enrollment period. This review process is in accordance with 42 CFR 438.56 and the Comprehensive Health Care Program and Healthy Kids Dental plan contracts. You will get a letter from MDHHS no later than the first day of the second month following the month in which your signed request form was received. MDHHS will consider a change in your plan due to:

- Concerns with quality of care.
  - Tell us what your concerns are with the quality of care and what you have done to work with the provider or plan.
- Lack of access to services or providers experienced in dealing with health or dental care needs.
  - Describe what you need and cannot get from your plan and what you or your providers have done to work with the plan to get the covered care or services you need.
- Lack of access to primary care within 30 miles / 30 minutes of where you live.
  - Show that there no primary care providers within 30 miles or minutes from where you live, that they are not taking new patients, or that you have been discharged as a patient.
- To continue medical or dental care with a provider that is actively treating a serious or ongoing medical or dental condition that no longer works with or accepts referrals from your current plan.

Beneficiary Instructions

- Section I should be filled out by the beneficiary, legal guardian, or authorized representative.
- Use one form for each beneficiary asking for the Special Disenrollment – For Cause review.
- Please print clearly.
- You or your legal guardian must sign the form. If you have someone helping you fill out the form that authorized representative must also sign the form. By signing the form, you verify that:
  - The information is true and complete to the best of your knowledge.
  - MDHHS can discuss your personal or enrollment information for this request only.
- Describe why you are asking for the change in plans, what actions you have taken to work with your plan before asking for this review, and why your plan is not able to provide your care or services.
- For requests based on medical or access to care or specialists, please have your provider fill out and sign Section II. You do not have to have a provider fill out this section to send the request in.

Provider Instructions

- Section II should be filled out and signed by the treating provider (doctor, dentist, other health / dental professional).
- Describe why a change in plans is needed for your patient and any actions you have taken to work with the current plan. If you terminated your contract with a plan, please indicate the date of termination, what other plans you work with, how long you have been treating the beneficiary, the treatment plan and the frequency of visits. Attach copies of additional medical or dental information to support a change in plans for your patient.

Please mail the completed form and any additional information in the enclosed return mail envelope to:

Michigan Enrolls
PO Box 30412
Lansing, MI 48909

If you have questions about this form or need help filling it out, you can call the Beneficiary Help Line at 1-800-642-3195 or TTY 1-866-501-5656.

Michigan Department of Health and Human Services (MDHHS)
Please note if needed, free language assistance services are available.
Call 800-642-3195 (TTY users call TTY:866-501-5656).

Spanish	ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-642-3195 (TTY:866-501-5656).
Arabic	ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-642-3195 (رقم هاتف الصم والبكم:-TTY:866-501-5656)
Chinese	注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-642-3195（TTY:866-501-5656）
Syriac (Assyrian)	ܙܘܗܪܐ: ܐܢ ܐܢܬ ܟܐ ܡܡܠܠܬ ܠܫܢܐ ܐܬܘܪܝܐ، ܟܐ ܡܨܝܬ ܕܦܠܚܬ ܒܚܠܦܘܬ ܕܗܝܪܬܐ ܒܠܫܢܐ ܡܓܢܐܝܬ. ܩܪܝ ܥܠ ܡܢܝܢܐ 800-642-3195 (TTY:866-501-5656)
Vietnamese	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-642-3195 (TTY:866-501-5656).
Albanian	KUJDES: Nëse flitni shqip, për ju ka në dispozicion shërbime të asistencës gjuhësore, pa pagesë. Telefononi në 800-642-3195 (TTY: 866-501-5656).
Korean	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-642-3195 (TTY:866-501-5656) 번으로 전화해 주십시오.
Bengali	লক্ষ্য করুনঃ যদি আপনি বাংলা, কথা বলতে পারেন, তাহলে নিঃখরচায় ভাষা সহায়তা পরিষেবা উপলব্ধ আছে। ফোন করুন ১-800-642-3195 (TTY ১-866-501-5656)
Polish	UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 800-642-3195 (TTY:866-501-5656).
German	ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer 800-642-3195 (TTY:866-501-5656).
Italian	ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 800-642-3195 (TTY:866-501-5656).
Japanese	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。800-642-3195（TTY:866-501-5656）まで、お電話にてご連絡ください
Russian	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-642-3195 (телетайп 866-501-5656).
Serbo-Croatian	OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 800-642-3195 (TTY Telefon za osobe sa oštećenim govorom ili sluhom 866-501-5656).
Tagalog	PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-642-3195 (TTY: 866-501-5656).

The Michigan Department of Health and Human Services will not exclude from participation in, deny benefits of, or discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, partisan considerations, or a disability or genetic information that is unrelated to the person's eligibility. Further, MDHHS:

- Provides free aids and services to people with disabilities to communicate with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats); and
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Section 1557 Coordinator. The contact information is found below.

If you believe that MDHHS has not provided services, or discriminated in another way, you can file a grievance with the Section 1557 Coordinator. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Section 1557 Coordinator is available to help you.

MDHHS Section 1557 Coordinator
Compliance Office, 4th Floor
P.O. Box 30195
Lansing, MI 48909

517-284-1018 (Main), TTY users call 711, 517-335-6146 (Fax),
MDHHS-ComplianceOffice@michigan.gov

You can also file a civil rights complaint with the responsible federal agency.

If your grievance or complaint is about your Medicaid application, benefits or services you can file a civil rights complaint with the U.S. Department of Health and Human Services at https://bit.ly/2pBS4YG, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW Room 509F, HHH Building Washington, D.C. 20201 800-368-1019, 800-537-7697 (TDD) Complaint forms are available at https://bit.ly/2IKsHMS.	If your grievance or complaint is about your application for or current food assistance benefits, you can file a discrimination complaint with the U.S. Department of Agriculture (USDA) Program by: Completing a Complaint Form, (AD-3027) found online at: https://bit.ly/2g9zzpU or at any USDA office, or write a letter addressed to USDA at the address below. In your letter, provide all of the information requested in the form. To request a copy of the complaint form, call 866-632-9992. Send your completed form or letter to USDA by mail: U.S. Department of Agriculture Office of the Assistant Secretary for Civil Rights 1400 Independence Avenue, SW Washington, D.C. 20250-9410 Fax: 202-690-7442; or Email: program.intake@usda.gov

MDHHS is an equal opportunity provider.