

Date _____

Cabinet for Health and Family Services
Department for Medicaid Services
Division of Program Quality & Outcomes
275 East Main Street, 6C-C
Frankfort, Kentucky 40621

Dear Sir/Madame:

My name is _____ and I am having Medicaid Member Services write a ***Disenrollment for Cause*** letter for me and _____. I am currently with the _____ managed care organization (MCO). I am writing to change my coverage to _____, so I can continue to receive services from my primary care doctor and/or receive my medications.

Here is my information:

Member(s):

SSN or Medicaid ID number:

Date of Birth:

Primary Care Provider:

Medication(s):

Reason for Disenrollment:

My contact phone number (between the hours of 8:00 a.m. – 5:00 p.m.) is: _____.

My mailing address is: _____

Thank you in advance for consideration of this request.

Sincerely,

SIGNATURE REQUIRED