Date: _____

To Whom It May Concern:

I,_____(first and last name) am seeking to change my MCO outside of Open Enrollment for the following reason (*include summary of contact you had with current MCO in order to resolve your issue and their response to your issue)*

_____
_____
_____
_____

My Case#:
My Social Security Number is:
My Medicaid ID# Is:
My Mailing Address Is:

Household Member(s) requesting change in MCO: _____
_____

My Phone Number That I could be reached at is:

1) ( ) -
2) ( ) -

My Primary Care Provider is: _____

The hospital that I use is: _____

The Following is a Complete List of My Medications: (Attach Additional Sheet if Necessary)

1)
2)
3)
4)
5)
6)
7)
8)
9)
10)

The MCO that I am seeking that I feel best meets my needs is: _____
Thank you for your time as I await the results of the above MCO Change Request.

Sincerely,

_____,_____
Signature Date

You may either fax or mail the request to:
Cabinet for Health and Family Services
Department for Medicaid Services
Division of Provider and Member Services
275 East Main Street, 6E-C
Frankfort KY 40621
Fax: 502-564-3852

Please be advised this process may take up to 90 days. If you have submitted your request and have questions, please contact the Division of Provider and Member Services at (800) 635-2570.