NC DEPARTMENT OF
HEALTH AND HUMAN SERVICES
Division of Health Benefits

Health Plan Change Request

Use this form to request to change your health plan.

If you want to request to change your health plan:

1. Talk to your health plan about your concerns. They may be able to help you stay in your plan.
2. If you still want to change your plan, you can change in one of these ways:
   - Go to ncmedicaidplans.gov
   - Use the NC Medicaid Managed Care mobile app
   - Call us at **1-833-870-5500** (TTY: 1-833-870-5588)
   - Fill out this form. Fax it to 1-833-898-9655. Or, mail it to NC Medicaid, PO Box 613, Morrisville NC 27560

▶ **Tell us about the head of household**			
First name	MI	Last name	
Date of birth		Medicaid ID Number	
Address			
City		State	ZIP Code
Phone number Home		Cell	
Email address			
What language do you speak at home? ☐ English ☐ Spanish ☐ Other?			

★ **Fill out this form for each person who wants to change their plan.**

Person 1	Name	Date of birth	Medicaid ID Number
▶ **Write the name of the plan you want here**.			

▶ **Tell us why you want to change your plan** (Put an X next to the reason or reasons you want to change plans. We may ask you to provide proof to support your request).

- ☐ Cannot get all needed health services in one plan
- ☐ Current plan cannot meet medical needs
- ☐ Long Term Services & Supports (LTSS) provider no longer in plan (write the provider's name below)

  _____

- ☐ Family member is in a different plan
- ☐ Poor performance of plan
- ☐ Plan will not cover service for moral or religious reasons
- ☐ Other (please explain why)

  _____

  _____

Questions? Go to ncmedicaidplans.gov. Or call us at **1-833-870-5500** (TTY: 1-833-870-5588), 7 a.m. to 5 p.m., Monday through Saturday. We can speak with you in other languages.

To get this information in other languages or formats such as large print or audio, call **1-833-870-5500**.

Person 2	Name	Date of birth	Medicaid ID Number

▶ **Write the name of the plan you want here**.

▶ **Tell us why you want to change your plan** (Put an X next to the reason or reasons you want to change plans. We may ask you to provide proof to support your request).

- ☐ Cannot get all needed health services in one plan
- ☐ Current plan cannot meet medical needs
- ☐ Long Term Services & Supports (LTSS) provider no longer in plan (write the provider's name below)

_____

- ☐ Family member is in a different plan
- ☐ Poor performance of plan
- ☐ Plan will not cover service for moral or religious reasons
- ☐ Other (please explain why)

_____

_____

Person 3	Name	Date of birth	Medicaid ID Number

▶ **Write the name of the plan you want here**.

▶ **Tell us why you want to change your plan** (Put an X next to the reason or reasons you want to change plans. We may ask you to provide proof to support your request).

- ☐ Cannot get all needed health services in one plan
- ☐ Current plan cannot meet medical needs
- ☐ Long Term Services & Supports (LTSS) provider no longer in plan (write the provider's name below)

_____

- ☐ Family member is in a different plan
- ☐ Poor performance of plan
- ☐ Plan will not cover service for moral or religious reasons
- ☐ Other (please explain why)

_____

_____

Sign and date

By signing below, I am stating that all information on this form is true. I know that if I gave false information on this form, my request to change my health plan may be denied.

▶ **Head of household or guardian** sign here Date

▶ **Authorized representative** If you are an authorized representative for this household, fill out this section and sign below.

Name of authorized representative	Phone number

Address (street, city, state, ZIP Code)

▶ Authorized representative sign here Date