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 health plan.
2. If you still want to change your health plan, you can change in one of these ways:
   - Go to ncmedicaidplans.gov
   - Use the NC Medicaid Managed Care mobile app
   - Call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com)
   - 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?			

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Questions? Go to ncmedicaidplans.gov. Or call us toll free at **1-833-870-5500** (TTY: 711 or RelayNC.com). We can speak with you in other languages.

You can get free auxiliary aids and services, including information in other languages or formats such as large print or audio.
Call us toll free at 1-**833-870-5500**.

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

Name	Date of birth	Medicaid ID number

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

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

- ☐ You moved out of your health plan's service area
- ☐ You have a family member in a different health plan
- ☐ You cannot get all the related services you need from providers in your health plan, and there is a risk to getting the services separately. You can attach proof or explain here:

  _____

  _____

  _____

  _____
- ☐ A different health plan may be better for your complex medical conditions. You can attach proof or explain here:

  _____

  _____

  _____

  _____
- ☐ Your Long-Term Services and Supports (LTSS) provider is not in your health plan (write the provider's name below)

  _____
- ☐ Your health plan does not cover a service you need for moral or religious reasons
- ☐ Other reasons (poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with your health care needs)

▶ Sign and date below

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