Complete
Personal and Direct Care

FAX: (866) 912-1869
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Disenrollment / Transfer Form

Please check all that apply:

◯ **Dental** ◯ **Vision** ◯ **Hearing** ◯ **Podiatry** ◯ **Behavioral Health**

Plan Member: _____ Member ID#: _____

Name of Facility: _____

Disenrollment: (Please check one)

◯ **Report of Death**
◯ **Moved Back to Community**
◯ **Can No Longer Pay Premium**
◯ **Other (explain here): _____**

◯ **Transfer To New Facility:** ___ In Arkansas? ___ Out of State?

Name of Facility: _____

City: _____ Phone: _____

Signature: _____
(Member, POA, Responsible Party, Facility Representative)

Effective Date: _____
(If Disenrollment, Last Day of Month)