NJFAMILYCARE
Affordable health coverage. Quality care.

# NJ FAMILYCARE DISENROLLMENT FORM

(PLEASE PRINT)

HEALTH PLAN YOU WANT TO DISENROLL FROM:

_____

YOUR NAME: _____

ADDRESS: _____

_____

PHONE NUMBER: ( _____ ) _____
AREA CODE

MEDICAID NUMBER: _____

FAMILY MEMBERS

| NAME | D.O.B. | Social Security No. |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Check reasons for wanting to disenroll:

___Long wait to get an appointment (PCP/Specialist)
___Long wait with an appointment at doctor's office (PCP/Specialist)
___Not happy with doctor's services/treatment
___Problem getting referrals
___Can't get prescriptions filled
___Problem with transportation
___Problem with after hours/emergency care
___Place to get care is not convenient
___Moving out of area
___Unable to get walk-in emergency services
___Doctor doesn't return phone calls
___Doctor doesn't return calls fast enough (30-45 minutes after hours; 1-2 hours during day)
___Doctor won't treat medical condition
___Want a doctor not in plan
___Doctor no longer with plan
___Not told about referral process
___Loss of eligibility
___Death
___Problems with how the plan works
___Other (Please explain):

_____

_____

I want to disenroll from the plan named above.

_____

Signature | Date | Completed By | Organization

_____
Member Services Contact

**NOTE: SOME MEDICAID FAMILIES MUST SIGN UP FOR ANOTHER HEALTH PLAN BEFORE THEY CAN DISENROLL. CALL A HEALTH BENEFITS COORDINATOR FOR HELP AT 1-800-701-0710 (TTY 1-800-701-0720.)**

**Rev 10/00** **FC-DIS-10/00**

THREE COPIES; CUSTOMER KEEPS COPY AND SUBMITS TWO