

HealthPlus of Michigan Member Discharge / Termination Request Form

Today's Date _____

Requesting PCP _____ Hospital Affiliation/PPG _____

Member Name _____ Member's Contract (ID) Number _____ - _____

Request to discharge _____ Member only _____ All members on contract

Reason for discharge / termination:

_____ The PCP was listed as NOT ACCEPTING in the HealthPlus provider directory at the time of open enrollment

_____ The enrollee's age is inconsistent with the PCP's practice (applies to pediatrics only).

_____ The member did not understand/does not want to use the PCP's affiliate hospital and is not willing to change hospital choice based on hospital affiliation.

_____ The member is undergoing established, long-term treatment with an in area specialist not associated with the PCP/PPG hospital and is not willing to switch his/her care to the PCP's specialist of choice

_____ The member has an unpaid financial debt with the PCP (incurred prior to becoming an HPM member) and is unable to reach a resolution or compromise with the PCP

_____ **Other. Must be clearly documented for review. Please attach a separate sheet.**

Please note: The discharge or termination of a physician/member relationship shall not be made on the basis of the member's health status.

_____ The issue was discussed with the member. Date discussed _____

_____ This issue was not discussed with the member.

Physician Signature

Date

Please forward this form to your PPG Medical Director for Review

For HealthPlus use only:

Date rec'd by HPM _____	PCP Notified _____	Effective Date _____
Reviewed by PPG Medical Director _____	Date _____	Determination _____
Rev'd by Regional Medical Director _____	Date _____	Determination _____
Reviewed by Plan Medical Director _____	Date _____	Determination _____