

HEALTHPLUS OF MICHIGAN MEMBER DISCHARGE / TERMINATION REQUEST FORM

NOTE: Member discharge letter cannot be sent to the member until determination by the HealthPlus Plan Medical Director.

Today's Date: _____ Requested Effective Date: _____
 Requesting PCP: _____ Hospital Affiliation/PPG: _____
 Member Name: _____ Member's Contract (ID) Number: _____
 Request to Discharge: _____ Member Only _____ All Member on Contract
 HealthPlus Product Line: _____

Reason for Discharge/Termination:

- _____ The enrollee's age is inconsistent with the PCP's practice.
- _____ 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 the PCP's 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 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 will not be made on the basis of the member's health status.

_____ This issue was discussed with the member. Date discussed: _____
 _____ This issue was not discussed with the member.

Discharging Physician Signature: _____ Date: _____

Reviewed by PPG Medical Director (I certify that this discharge has been reviewed and all documentation is complete):	Print Name:	Signature:
Reviewed by Plan Medical Director:	Print Name:	Signature: