

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 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 (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 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.

Physician Signature:

Date:

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: _____