Standard Plan Change Request

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Fill out and submit this form *faster* online at ncmedicaidplans.gov/en/submit-forms-online.

Who is this form for?

This form is for beneficiaries (people with Medicaid) enrolled in a Standard Plan who have a reason to change to a different Standard Plan.

If a beneficiary wants to change their Standard Plan

- Talk to the Standard Plan first about any concerns. They may be able to help the beneficiary stay in their Standard Plan.
- If you still want to change the beneficiary's plan, the easiest way is to log in to the beneficiary's NC Medicaid Managed Care account. You will need to have the NCID to log in and request to change the Standard Plan.

Who can fill out this form?

- You can fill out this form for yourself.
- Your legally responsible person, such as the head of household, legal guardian or authorized representative, can fill out the form for you.

Two ways to send this signed form to NC Medicaid:

Mail
NC Medicaid
PO Box 613
Morrisville, NC 27560

Fax
1-833-898-9655

Next steps

Once we get the signed document, NC Medicaid will review this request.

If we **approve** the request, we will send a letter to tell the beneficiary when they will start getting Medicaid services through the new Standard Plan.

If we **deny** the request, we will send a letter to tell the beneficiary they will stay in their current Standard Plan. The letter will tell the beneficiary how to appeal if they do not agree with our decision.

1 Tell us about the person who wants to change their Standard Plan

If more people in your household want to change their Standard Plan, you will need to fill out a form for each person.

Beneficiary first name	Beneficiary middle name
Beneficiary last name	Date of birth (MM/DD/YYYY)
NC Medicaid ID number	

Standard Plan beneficiary has **now** (check one):

☐ AmeriHealth Caritas ☐ HealthyBlue ☐ Carolina Complete Health
☐ UnitedHealthcare Community Plan ☐ Wellcare

Standard Plan beneficiary wants to **move** to (check one):

☐ AmeriHealth Caritas ☐ HealthyBlue ☐ Carolina Complete Health
☐ UnitedHealthcare Community Plan ☐ Wellcare

2 Contact information

Tell us about the beneficiary's legally responsible person, if different from beneficiary. This includes the head of household, a legal guardian or an authorized representative.

Beneficiary or legally responsible person first name		Middle name
Beneficiary or legally responsible person last name		Date of birth (MM/DD/YYYY)
NC Medicaid ID number		
Address		
City	State	ZIP Code
Home phone number	Cell phone number	
Email address		
What language is spoken at home? ☐ English ☐ Spanish ☐ Other _____		

3 Tell us why the beneficiary wants to change their Standard Plan

Check **all** reasons that apply. To support the request, you may also attach relevant documents. This helps us review your request faster. This is optional.

☐ Beneficiary moved out of the Standard Plan's service area.

☐ Beneficiary has a family member in a different Standard Plan.

☐ Beneficiary cannot get all the related services they need from providers in the Standard Plan and there is a risk to getting the services separately. You can attach proof or explain here:

☐ A different Standard Plan may be better for the beneficiary's complex medical conditions. You can attach proof or explain here:

☐ The beneficiary's Long-Term Services and Supports (LTSS) provider is not in the Standard Plan. Provider first name, last name and phone number:

☐ The Standard Plan does not cover a service the beneficiary needs for moral or religious reasons.

☐ Other reasons (poor quality of care, lack of access to covered services, lack of access to providers experienced in dealing with beneficiary's health care needs). You can attach proof or explain here:

4 Read below and sign to submit this form

The beneficiary or legally responsible person **must** read and sign.

By signing below, I am stating that all information on this form is true. I know that if I gave false information on this form, my request to change the Standard Plan may be denied.

Signature of beneficiary or legally responsible person ▶	Date
Printed name ▶	