<Date>
<Member Name>
<Address>
<City, State> <Zip Code>

Intent to Disenroll Notice

<Member ID.>
<Client Identification Number>

Dear <Member Name>,

This is an important notice about your enrollment in <Plan Name>. We are writing because we have submitted an involuntary disenrollment request to New York Medicaid Choice because <**Involuntary Disenrollment Reason**>.

What Happens Now

New York Medicaid Choice (NYMC) must review and agree with <Plan Name>'s involuntary disenrollment request. If approved, we expect the disenrollment to be effective by <Anticipated Effective Date>.

We will notify you when your disenrollment is complete. Until that time, we will continue to provide you with the covered services you are now receiving.

What Happens Next

If your involuntary disenrollment is approved by NYMC, you will be provided a disenrollment letter from NYMC which includes fair hearing rights.

*{Insert **ONLY ONE (1)** based on the disenrollment outcome, see Appendix 3.}*

[*{insert as applicable}* ***<Disenrolled to Fee-for-Service:*** Once disenrolled, your Medicaid benefits will be continued under Medicaid fee-for-service using your Medicaid card.***>***

[*{insert as applicable}* ***<Mandatory to MLTCP:*** Once the disenrollment is approved by NYMC, NYMC will contact you to assist you with picking a different Managed Long Term Care plan.***>***

[*{insert as applicable}* ***<Voluntary to MLTCP:*** Once the disenrollment is approved by NYMC, to continue to receive services, you will need to speak with NYMC to pick a different Managed Long Term Care plan. NYMC will contact you to pick another plan.***>***

We will work with you to transfer your care to other providers prior to the disenrollment effective date. Your <Care Manager> will call to discuss your

transfer plan and preferences for continued care following disenrollment from <Plan Name>.

What You Can Do Now

- Share this letter with your family or someone who knows about your health care needs.

- Call <Plan Name>. Please call us at <Plan Phone Number>, <Hours of Operation> if you have any questions, if you feel information in this letter is incorrect or wish to work with us to maintain enrollment. For TTY, call <TTY Number>.

  *insert only **ONE (1)** based on the involuntary disenrollment needs, see Appendix 3}*

  [*{insert as applicable*} ***Out of the service area: <*** If you have returned to community and wish to reinstate your service plan, please contact us immediately.**>**

  [*{insert as applicable*} ***No CBLTSS: <***If you wish to reinstate your service plan, please contact us immediately.**>**

  [*{insert as applicable*} ***Hospitalized or in a residential program: <***If you have a plan to return to the community or would like assistance in returning to the community, please contact us immediately.>

  [*{insert as applicable*} ***Unaligned Medicare enrollment: <***If you have or will reenroll in the [Insert Plan Name]'s Medicare plan, please contact us immediately.**>**

  [*{insert as applicable*} **Refused Assessment: <** If you wish to schedule and complete your assessment, please contact us immediately.**>**

You can call the Independent Consumer Advocacy Network (ICAN) to get free, independent
advice about your coverage, complaint, and appeal options. They can help you manage the appeal process. Contact ICAN to learn more about their services:
Phone: 1-844-614-8800 (TTY Relay Service: 711)
Web: www.icannys.org | Email: ican@cssny.org

<Salutation>

Thank you.

<Notice of Non-Discrimination>

<Multi-Language Insert>