Involuntary Member Disenrollment Request Form

For MassHealth members

WellSense HEALTH PLAN

Please review the WellSense Involuntary Member Disenrollment Policy.

PCP Information

PCP name

Group name | Group NPI

Address

City | State | Zip

Phone | Contact Name

Remit address

City | State | Zip

Phone | Fax

Member Information

Name

Member ID #

Parent/Guardian name

Address

City | State | Zip

Phone

Date of birth

Please provide a thorough, objective explanation of the reason for the involuntary transfer request. Describe how the member's behavior has impacted the provider's ability to arrange for or provide services to that member or to other members of the Plan.

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A description of the precipitating event:

Statements from the Provider(s) describing their experience with the member and any required intervention by Security or Police:

Please provide any information from the member (e.g. complaints, statements)

Please describe the member mental and functional status at the time of the incident.

Please provide an outline with supporting documentation of the serious efforts made to resolve the precipitating concern with the Member, including the provision of reasonable accommodations.

Please describe the Member's social support systems.

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Please provide any additional relevant information.

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Attestations:

By signing below, I attest to the following:

- The Member received at least one (1) written notification in advance of the decision to request an involuntary disenrollment from the practice.
- The Member's behavior is not related to the use, or lack of use, of medical, behavioral or other services.

Signature: _____

Printed name: _____

Title: _____

Date: _____

Submit or fax completed form to:
617-897-0884
Attn: Provider Services