REQUEST FOR TERMINATION DUE TO ECF STAY

Patient Name: _____

ID Number/MMIS Number: _____

Case Number: _____

Facility Name: _____

Admission Date: _____

Discharge Date: _____

Requested Disenrollment Date: _____

Facility Representative: _____

Title/Department/Phone: _____

Date Signed: _____

Fax the completed form and documentation to:
Molina Healthcare of Ohio
Attn: Enrollment Department
Fax: 1-855-714-2414
Phone: 1-800-357-0146

Remember to attach documentation of the admission and discharge dates, and the Level of Care (LOC).

Your request will be submitted to the Ohio Department of Medicaid (ODM). Website eligibility should be updated within 2 weeks of submission from Molina Healthcare of Ohio to ODM.

Thank you!