Oregon Health Authority

Member Request for Temporary Fee-for-Service (FFS) Health Care

When to use this form

Use this form only if you have a health related reason to leave your coordinated care organization (CCO). A request for disenrollment based on continuity of care shall be denied if the basis for the request is primarily for the convenience or preference of the member for a provider of a treatment or a supply. Please do **not** use this form if you are American Indian or Alaska Native *(please instead use the OHP 0720)*.

You can read the laws and rules about being in a CCO in Oregon Revised Statute chapter 414 (Medical Assistance) and within the Oregon Health Plan (MCE and CCO) Administrative Rulebook Chapter 410, Division 141.
Instructions are as follows:

- **Member:** Talk to your CCO about your health care needs. If your needs are not met, fill out and sign this form. Take it to your doctor or primary care provider (PCP).
- **PCP:** Email this form to OHA with pertinent clinical records and a letter of clinical necessity to OHA, using the address (Temp.ContinuityofCareExemptionRequests@dhsoha.state.or.us). Please follow the FFS medical review instructions on the OHP website at http://bit.ly/cco-disenrollment.

In 30 calendar days or less, OHA will send you a decision letter. Approved requests are active on the date of approval, and your decision letter will also tell you when your FFS coverage expires. If FFS coverage extensions are necessary, please submit subsequent FFS renewal requests 30 days prior to the date of expiration of the current approval.

Reason for change

1. A request for FFS coverage requires contact with your CCO care coordination team before consideration. Please print the name and title of the person you contacted and the date you discussed your current health care needs:

   Name ________________ *Job title* ________________ *Date* ________

2. Mark the service(s) which are not able to be met by your assigned CCO:

   ☐ Mental health ☐ Dental ☐ Medical

   *Mental Health disenrollment will result in disenrollment of all health services

3. Please tell us why you need FFS Oregon Health Plan (OHP) coverage. *If needed, write more in the open space provided on page 2.*

Member information

4. Name:		
Last	*First*	*Middle initial*
5. Date of birth:	6. Oregon Medicaid ID:	
7. Your CCO's name *(including plan name if applicable)*:		
8. Your medical doctor or PCP's name *(if seeking medical disenrollment)*:		
Your mental health provider's name *(if seeking mental health disenrollment)*:		
Your dental provider's name *(if seeking dental disenrollment)*:		

Additional information to provide clinical justification for disenrollment** (section 3)**:

Member's signature

Signature of member or member representative - *Representative must have proof of legal authority to sign for this member available upon request.*

Date

Name of representative *(printed)*: ____________________ Relationship to member: ____________