Case DCN: ____________

HEALTH PLAN CHANGE FORM

Your request to change plans must be received before your change period deadline. Please check the box next to the health plan you are selecting and print the name of your preferred Primary Care Provider (PCP). If you do not enter the name of a PCP, one will be selected for you. Leave the sections blank for any member who is not changing.

Name: ____ **DCN:** _____________________

Healthy Blue

Home State Health

United Healthcare Community Plan

PCP Name: ___________________________ PCP's Phone Number: _______________________

PCP Address: ____

Name: ____ **DCN:** _____________________

Healthy Blue

Home State Health

United Healthcare Community Plan

PCP Name: ___________________________ PCP's Phone Number: _______________________

PCP Address: ____

Name: ____ **DCN:** _____________________

Healthy Blue

Home State Health

United Healthcare Community Plan

PCP Name: ___________________________ PCP's Phone Number: _______________________

PCP Address: ____

See other side

Name: ____ **DCN:**____________________

Healthy Blue

Home State Health

United Healthcare Community Plan

PCP Name: __________________________ PCP's Phone Number: ______________________

PCP Address: ____

Name: ____ **DCN:**____________________

Healthy Blue

Home State Health

United Healthcare Community Plan

PCP Name: __________________________ PCP's Phone Number: ______________________

PCP Address: ____

(If there are more members in your case and you need more space, attach another sheet of paper.)

I choose the Health Plan(s) selected above to manage all covered health care services for each person on my case. I have made a free choice of the Health Plan(s) and PCP(s) available to me.

SIGNATURE: ____

RELATIONSHIP/TITLE: __________________________________ DATE: _________________

Did your address change?

Report address changes to Family Support Division online at mydss.mo.gov or call 1-855-373-4636.