MANAGED CARE HEALTH PLAN CHANGE FORM

Member Identification		
Primary Contact: Name	Region:	Date: 00/00/0000
Case DCN: 00000000		

ID Number	Member Name	Assigned MO HealthNet Managed Care Health Plan	Deadline to Change	Check one health plan	PCP Name (first and last name)	Do you have other Insurance?
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No
00000000	Name	Health Plan Name	00/00/0000	☐ xx - Unitedhealthcare Of The Midwest Inc ☐ xx - Healthy Blue ☐ xx - Home State Health Plan Inc		☐ Yes ☐ No

☐ I choose the Health Plan(s) written 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:** ________________