Enhanced Care Management (ECM) Disenrollment Form

Health Plan of San Joaquin | Mountain Valley Health Plan

ECM Provider Details	
Provider Name:	
Lead Care Manager:	
Phone:	**Fax:**
Email:	

Member Details	
Member Name:	
HPSJ/MVHP ID#:	**Date of Birth:**

Disenrollment Details

Disenrollment Date:

Reason for Disenrollment: *(Select one from the following)*

- ☐ Unable to Reach
- ☐ Goals Met
  (Please submit completed care plan.)
- ☐ Member Request
  - ☐ Opted Out
  - ☐ Change of ECM Provider
- ☐ Downgrade to Lower Level of Case Management
  (Submit referral via Provider Portal.)

Additional Notes/Ongoing Needs

Please submit this form and any supporting documentation via fax to HPSJ/MVHP's Case Management Department at 209-762-4720.