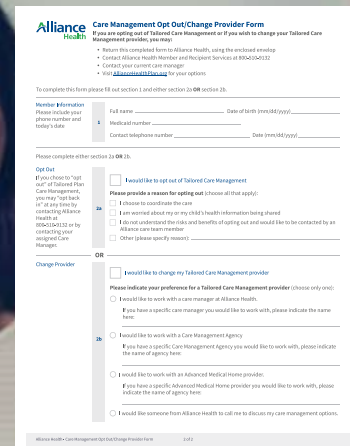


## Opting out of Tailored Care Management



**Alliance Health** Care Management Opt Out/Change Provider Form  
If you are opting out of Tailored Care Management or if you wish to change your Tailored Care Management provider, please use this form.

- Return this completed form to Alliance Health, using the enclosed envelope.
- Contact Alliance Health Member and Recipient Services at 800-424-1122.
- Contact your current care manager.
- Visit [alliancehealthplan.org](https://alliancehealthplan.org) for your options.

To complete this form please fill out section 1 and either section 2a OR section 2b.

**Member Information:**  
Please include your phone number and today's date.

1. Full name \_\_\_\_\_ Date of birth (mm/dd/yyyy) \_\_\_\_\_  
2. Medicaid number \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_  
3. Contact telephone number \_\_\_\_\_

Please complete either section 2a OR 2b.

**Opt Out:**  
If you choose to "opt out" of Tailored Care Management, please provide a reason for opting out (choose all that apply):

2a. ☐ I would like to opt out of Tailored Care Management.

Please provide a reason for opting out (choose all that apply):

☐ I choose to coordinate the care.  
☐ I am worried about my or my child's health information being shared.  
☐ I do not understand the risks and benefits of opting out and would like to be contacted by an Alliance care team member.  
☐ Other (please specify reason): \_\_\_\_\_

**OR**

**Change Provider:**

☐ I would like to change my Tailored Care Management provider.

Please indicate your preference for a Tailored Care Management provider (choose only one):

☐ I would like to work with a care manager at Alliance Health.  
If you have a specific care manager you would like to work with, please indicate the name here: \_\_\_\_\_

☐ I would like to work with a Care Management Agency.  
If you have a specific Care Management Agency you would like to work with, please indicate the name of agency here: \_\_\_\_\_

☐ I would like to work with an Advanced Medical Home provider.  
If you have a specific Advanced Medical Home provider you would like to work with, please indicate the name of agency here: \_\_\_\_\_

☐ I would like someone from Alliance Health to call me to discuss my care management options.

Member Health Information is Protected Under HIPAA. 1 of 2

## What is “opting out of Tailored Care Management”?

Care Management Agencies (CMAs) and Advanced Medical Homes + (AMH+s) are required to attempt to engage all assigned members in their panel in Tailored Care Management. However, members may choose to opt out of receiving Tailored Care Management. CMAs and AMH+s are required to notify the member's Tailored Plan when a member chooses to opt out.

## Why is it important to notify Tailored Plans when members opt out?

If a member opts out of Tailored Care Management, the member will be taken off the assigned CMA/AMH+'s panel and re-assigned back to the member's Tailored Plan. If the Tailored Plan is not notified that the member has opted out, the member will not be re-assigned and the assigned CMA/AMH+ will continue to be responsible for continuing to engage that member, as well as for any crisis needs of the member. Additionally, the CMA/AMH+ will continue to receive that member's ADT feeds instead of the Tailored Plan.

## How do CMAs/AMH+'s inform Tailored Plans of member opt-outs?

If during the engagement process a member informs their assigned CMA/AMH+ of their choice to opt out of Tailored Care Management, the CMA/AMH+ must inform the member's Tailored Plan. If the member is an Alliance member, the CMA/AMH+ will document the member's decision to opt out on the Care Management Opt Out/Change Provider Form (page 2) and **securely** email the completed form to Alliance's Member and Recipient Services at [asupport@AllianceHealthPlan.org](mailto:asupport@AllianceHealthPlan.org). The CMA/AMH+ must also document that the member has opted out in their own care management platform and upload the completed opt-out form into the member's record. Once Alliance receives the completed opt-out form, the member will be removed from the CMA/AMH+'s panel and assigned back to Alliance for monitoring and care management.

## Additional Tips:

- CMAs/AMH+'s must make sure that the opt-out form is sent to the correct Tailored Plan. Forms sent to the wrong Tailored Plan would violate HIPAA.
- Alliance's opt-out form is specific to Alliance; Alliance will not accept forms from other Tailored Plans.
- The opt-out form is only available in PDF format. Providers will need to print it out to complete it, then scan the completed form so that it can be emailed to Alliance.
- It is essential that providers document that the member has opted-out in their own system, and keep the member's opt-out form in the member's record.
- When opt-out forms are emailed to Alliance, these forms **must** be sent via secure means (for example: encrypted) to keep the members' protected health information confidential.

## References:

RFA Section V.B.3.ii (iv) (p. 127-128)



## Care Management Opt Out/Change Provider Form

If you are opting out of Tailored Care Management or if you wish to change your Tailored Care Management provider, you may:

- Return this completed form to Alliance Health, using the enclosed envelope
- Contact Alliance Health Member and Recipient Services at 800-510-9132
- Contact your current care manager
- Visit [AllianceHealthPlan.org](https://AllianceHealthPlan.org) for your options

To complete this form please fill out section 1 and either section 2a **OR** section 2b.

### Member Information

Please include your phone number and today's date

1

Full name \_\_\_\_\_ Date of birth (mm/dd/yyyy) \_\_\_\_\_

Medicaid number \_\_\_\_\_

Contact telephone number \_\_\_\_\_ Date (mm/dd/yyyy) \_\_\_\_\_

Please complete either section 2a **OR** 2b.

### Opt Out

If you chose to “opt out” of Tailored Plan Care Management, you may “opt back in” at any time by contacting Alliance Health at 800-510-9132 or by contacting your assigned Care Manager.

2a

☐

I would like to opt out of Tailored Care Management

**Please provide a reason for opting out** (choose all that apply):

☐

I choose to coordinate the care

☐

I am worried about my or my child's health information being shared

☐

I do not understand the risks and benefits of opting out and would like to be contacted by an Alliance care team member

☐

Other (please specify reason): \_\_\_\_\_

**OR**

### Change Provider

2b

☐

I would like to change my Tailored Care Management provider

**Please indicate your preference for a Tailored Care Management provider** (choose only one):

☐

I would like to work with a care manager at Alliance Health.

If you have a specific care manager you would like to work with, please indicate the name here:

☐

I would like to work with a Care Management Agency

If you have a specific Care Management Agency you would like to work with, please indicate the name of agency here:

☐

I would like to work with an Advanced Medical Home provider.

If you have a specific Advanced Medical Home provider you would like to work with, please indicate the name of agency here:

☐

I would like someone from Alliance Health to call me to discuss my care management options.