State of Oregon
Department of Human Services
Division of Medical Assistance Programs

Program	Branch	Case Number	Worker ID
Case Name			

Request to Terminate Insurance

To: ____
(Name of Insurance Company/Medicare Advantage Plan)

From: ____
Last First Middle

Address: ____

____
City Zip Code County

Phone: __________________________ Date of Birth _________________

Medicare Number : ________________________________

Policy or Health Plan Number: ______________________

I request the health insurance/Medicare Advantage Plan I purchase through your company be ended effective:____________

I understand that your company will not pay any of my medical bills incurred after the actual termination date.

Medicare Advantage Plan Only: I understand I must continue to use the Medicare Advantage Plan named above until the effective date.

I am enrolling in: ____

Note: It may take Medicare a month to process your disenrollment. If Medicare denies bills they receive before you are disenrolled, ask your providers to resubmit these bills.

Signature: _____________________________ Date:_________________

If signer is not the client indicate
your relationship to client______________________ Phone:___________

Agency Use Only	**Complete fully before routing.**		
Prime #	**Branch #**	**Agency Contact**	**Contact Phone #**

Distribution: White – Insurance/MAPD Yellow – DMAP/HIG Pink – Case File Blue – Client

HMO/Other Health Insurance Termination Guidelines:

1. Client completes the OHP 7209 to request termination of HMO membership or coverage by other health insurance.
2. Worker sends the OHP 7209 to the Medicare Advantage plan or insurance company. The form must arrive at the Medicare Advantage Plan/insurance office by the last working day of the month termination is to be effective.
3. Worker sends a copy of the OHP 7209 to the Health Insurance Group, DMAP, to correct the third-party resource computer file (ELGX/ELGT).
4. Do not use the AFS 415H in conjunction with the OHP 7209.