



## **MEDICAL ASSISTANCE DIVISION**

### **Request to Switch Managed Care Organization (MCO) Health Plan During Lock-In Period**

Members can ask to change their Managed Care health plan outside of their open enrollment period, but must have a “for cause” reason, as defined in state rule 8.308.7.9.I NMAC.

Member Name (please print): \_\_\_\_\_

Date of Birth \_\_\_\_\_

Member Name (please print): \_\_\_\_\_

Date of Birth \_\_\_\_\_

Complete Mailing Address: \_\_\_\_\_

City, State, Zip Code: \_\_\_\_\_

CYFD Representative (if applicable): \_\_\_\_\_

Phone Number: (       ) \_\_\_\_\_ - \_\_\_\_\_

Email Address: \_\_\_\_\_

**NEW HEALTH PLAN CHOICE:**    ☐ Presbyterian    ☐ Blue Cross & Blue Shield of New Mexico  
                                                 ☐ United Healthcare    ☐ Molina Healthcare

By signing below, you are attesting that all information provided on this form is accurate.

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Date**

#### **Please explain why you are requesting to change your health plan:**

(Providing a reason does not guarantee approval.

If this field is left blank the request will be denied.)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Physician's Full Name:** \_\_\_\_\_

**Physician's Phone Number:** (       ) \_\_\_\_\_ - \_\_\_\_\_

## Health Plan Switch Request Process – Instructions

- Turquoise Care members may change health plans during their open enrollment period, or in their first three (3) months of initial enrollment by logging into their Yes New Mexico account at <https://yes.nm.gov/>, or by calling the HCA Customer Service Call Center at **1-800-283-4465**.
- To request to change health plans outside of the open enrollment period, members must submit the MAD776 Form to HCA/MAD, or submit a written request that includes all information for each member requesting to change health plans:
  - Name of each member,
  - Date of birth for each member,
  - Current mailing address, including city, state and zip code, for each member,
  - Reason for each member's request to switch,
  - Doctor's name and office phone number (as applicable) for each member,
  - Authorized representative's phone number with area code, if applicable,
  - Authorized representative's email address, and
  - Name of the health plan the member is asking to switch to.

**Members with Legal Guardian/Power of Attorney must submit proof of guardianship with every MCO/Health Plan switch request.**

**FAX TO:** 505-827-7200 or  
**MAIL TO:** Health Care Authority, Medical Assistance Division  
Attn: CEB – MCO/Health Plan Switch Request  
PO Box 2348  
Santa Fe, NM 87504-2348

HCA responds in writing to all health plan switch requests in accordance with 8.308.7.9.I NMAC.