



SoonerCare Dismissal Request Form

Date of Request:
Date Received by OHCA:
FAX Number: 405-530-7243

Name of Provider(s) with Provider <i>SoonerCare</i> ID#(s):
Point of Contact:
Phone Number:

This serves as a formal request to dismiss the following *SoonerCare* members from our panel:

Name of Member(s):	Member ID(s):

Please note dismissal requests from a PCP must be "For Cause". Please provide additional information in the field provided. **Please provide any pertinent chart notes as an attachment to this form.**

I wish to dismiss the member(s) for the following reason:

- Rude/Disruptive Behavior (give specific examples):
- Non-compliance with medical regime (give specific examples):
- Deterioration of provider/patient relationship (give specific examples):
- No Shows (give specific dates):

For OHCA Use Only

Dismissal Committee Review Comments:	
Provider Representative: _____	
Referred To:	CM <input type="checkbox"/> MS <input type="checkbox"/> BH <input type="checkbox"/> COP <input type="checkbox"/> QA <input type="checkbox"/> OTHER <input type="checkbox"/>
Letter of approval sent to Provider:	<input type="checkbox"/>
Attached copies of dismissal letters:	<input type="checkbox"/> APPROVED: <input type="checkbox"/>
Disenrolled and locked-out from PCP:	<input type="checkbox"/> DENIED: <input type="checkbox"/>
Logged in Excel Database	<input type="checkbox"/>
_____ Approved By: Date	