maryland health connection℠

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Maryland Health Connection Coverage Termination Form

Complete and submit this form to terminate your household's active coverage through Maryland Health Connection.

This form can only be used if you wish to terminate your entire household from active coverage. Be sure to submit your request before the end of the month you would like coverage to end. Requests will only be accepted for the current month or a future month.

Do NOT use this form if you have already been terminated from coverage through Maryland Health Connection or if you want to terminate only part of your household from coverage. If you need assistance or have questions, please click here to find free help.

Please note the Coverage Termination Form should NOT be used if you intend to renew or change plans for 2016.

To terminate Qualified Health Plan coverage: ☐ Health ☐ Dental

Primary Applicant Last Name | Primary Applicant First Name | M.I.

Residential Mailing Address | City | ZIP Code

To terminate Medicaid/MCHP coverage:

Note, Medicaid is a no-cost medical assistance program. If you are eligible for Medicaid, but choose to terminate Medicaid coverage, you are not eligible for advanced premium tax credits and/or cost sharing reductions associated with a qualified health plan (45 CFR 155.305(c)). You may reapply to Medicaid at any time, but you must meet eligibility criteria to be re-enrolled. Disenrollment requests may not be appealed.

List the members of your household who are enrolled in Medicaid. To use this form, you must request termination for all members. If you want to terminate coverage for only some members of your household, do not use this form, but click here to find free help.

Last Name	First Name	Relationship	Date of Birth	Medical Assistance Number

(If you have additional household members, please provide information on a separate piece of paper and attach to this form.)

Contact Information:

Phone Number | E-mail | Preferred Contact

I request to terminate coverage on the last day of (write month):

We need 7-10 business days from when we receive this form to process and complete your request. To finish this form, sign and date below.

Required Primary Applicant (or Authorized Representative) Signature | Date

Submit:

Save

Print

Fax to:
1-855-642-8574

or

Mail to:
Attn: Terminations
Maryland Health Connection
P.O. Box 857
Lanham, MD 20703-0857