OneCare Kansas Member Discharge Notification Form

Instructions

This form is for discharging members from the OneCare Kansas (OCK) program due to catastrophic illnesses or events that make it unlikely the member will continue to benefit from OCK. To request a discharge, the OneCare Kansas Partner (OCKP) must complete the first three sections of the form. Once completed, the form should be sent to the assigned Managed Care Organization (MCO) using the contact information provided below. The form can be submitted to the MCO through fax, secure HIPPA compliant email, MCO portals, or standard mail.

The MCO will then review and complete the remaining sections of the form for discharge determination. Follow-up letters regarding the discharge determination will be sent to the member and OCKP.

MCO Contact Information		
Aetna Better Health of Kansas Attention: Member Services 9401 Indian Creek Pkwy, Suite 1300 Overland Park, KS 66210 Email Aetna Better Health of Kansas Phone: (855) 221-5656 Fax: (959) 282-8852	**Sunflower Health Plan** 8325 Lenexa Drive, Suite 200 Lenexa, KS 66214 Email Sunflower Health Plan Phone: (877) 644-4623 Fax: (888) 453-4317	**United Health Care OneCare Kansas** 6860 W 115th St. Mail Route: KS015-M400 Overland Park, KS, 66211 Email United Health Care Phone: (877) 542-9238 Fax: (855) 252-9324

Section I: OCK Partner Information

Provide the following information for the OCKP initiating the request.

Partner Name: _____

Primary Contact Name: _____

Title of Primary Contact: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Email:** _____

Section II: Member Information

Provide the following information regarding the member for whom the discharge request is being made.

MCO Assignment: ☐ Aetna ☐ Sunflower ☐ United **Medicaid ID Number:** _____

Member Name: _____ **Date of Birth:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____

Section III: Discharge Request

Provide the following information concerning the member's discharge request.

Date of Request: _____

Select the reason for the member's discharge request:

☐ Member is terminally ill, in an institution, or long-term care facility

☐ Member has lost their KanCare eligibility

☐ Member is deceased *

* If known, provide date of death: _____

☐ Member is incarcerated

☐ Other reason: _____

Section IV: MCO Discharge Determination

The following fields are to be completed by the MCO processing the member's discharge request.

Notice is hereby provided that the OneCare Kansas Partner's request to discharge the member named above is:

☐ Approved

☐ Denied *

*** Specify reason for discharge denial:**

Section V: MCO Follow-Up

The following fields are to be completed by the MCO processing the member's discharge request.

MCO Representative Name: _____

Title of MCO Representative: _____ **Phone Number:** _____

Date Discharge Notice Received: _____ **Date Discharge Reviewed:** _____

Discharge Request Granted by MCO: ☐ Yes ☐ No **Discharge Date:** _____

Date Response Letters Mailed: _____

Select Corresponding Follow-up Letters Sent:

☐ OneCare Kansas Member Discharge Notice of Action

☐ OneCare Kansas Partner Discharge Request Response Letter