

MEDICAID CARE CONNECT DECLINE TO PARTICIPATE FORM

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I understand that I may choose not to participate in the Care Connect Program. Please complete this form and return to CMForms@state.sd.us or mail to: Division of Medical Services, 700 Governors Dr., Pierre, SD 57501. For questions call (605) 773-3495.

I choose not to participate in the Care Connect Program

I, _____, do not want to participate in Care Connect at this time.
(Name, Please Print)

I know that I can choose to participate in Care Connect at any time if I am eligible for the program.

Signature

Medicaid Number

Reason for declining to participate (Please check all that apply)

My provider is not a Care Connect Provider

I don't understand the program, please call me at _____

Other (please explain) _____