

HEALTH HOME OPT-OUT FORM

Member Name: _____

Date of Birth: _____

Member ID Number: (9 digits) _____

I understand that I may choose not to participate in the Health Home pilot program provided by the South Dakota State Employee Health Plan.

Type of Request:

- Before I opt-out, I would like to be contacted. Complete Section A or contact DAKOTACARE at 1.800.831.0785.
- I want to Opt-Out. Complete Section B.

SECTION A:

My preferred contact method is:

- Phone: _____ Best Time is: _____ AM | PM
- Email: _____

SECTION B: You must check the two boxes below:

- At this time I am electing to decline participation in the program.
- I understand that I may choose to enroll in the Health Home at any future time.

Reasons for Opt-Out – check all that apply:

- My provider does not participate with the Health Home program, and I do not wish to change providers.
- I do not want to participate.
- Other, please explain: _____

If you have any questions regarding the form, please contact
DAKOTACARE at 1.800.831.0785

Form Return Options:

Email: healthhomestateplan@dakotacare.com **FAX:** 605.274.3291

Mail to: DAKOTACARE PO BOX 7406 SIOUX FALLS, SD 57117-7406