



Health Plan Change Form

**If you are happy with your current health plan it will stay the same.
Only complete this form if you want to change health plans.**

Please fill out every section **ONLY** for members who want to change health plans.
Sign, and date the form.

Head of Household Information

Head of Household (HOH) Name: _____

HOH Medicaid ID or PIN: _____ Phone #: _____

Address: _____ State: _____ Zip Code: _____

Members(s) First and Last Names	Date of Birth	Medicaid ID # (SSN or PIN)	Health Plan Change Request Check the name of the health plan you wish to change to. Each person in your household can have a different plan.
			<input type="checkbox"/> Molina Healthcare of Nebraska <input type="checkbox"/> Nebraska Total Care <input type="checkbox"/> UnitedHealthcare Community Plan of Nebraska
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More room is available on the back to make a change for additional members in your household.

I would like to change to the health plan(s) I selected. The information is correct. I understand that I will need to contact the Heritage Health Enrollment Center if I wish to make another health plan change.

Head of Household Signature: _____ Date _____

Heritage Health Enrollment Center 9370 McKnight Road, Suite 300 Pittsburgh, PA 15237
Toll-free Helpline 1-888-255-2605 TTY users ONLY call 711
Call Center Hours: Monday-Friday 7am -7pm Central Time
www.neheritagehealth.com

Additional members:

Members(s) First and Last Names	Date of Birth	Medicaid ID # (SSN or PIN)	Health Plan Change Request Check the name of the health plan you wish to change to. Each person in your household can have a different plan.
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Use the pre-paid envelope in this packet to mail this form to:

Heritage Health Enrollment Center
 9370 McKnight Road, Suite 300
 Pittsburgh, PA 15237

OR

Fax the completed form to:
 1-800-852-6311

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