



Primary Care Provider (PCP) Member Dismissal Form

Molina Healthcare of Florida, Inc.

Instructions:

1. Please follow instructions as indicated on the Provider Manual regarding PCP dismissals:
[Provider Manual and Orientation](#)
2. Submit this form with supporting documentation to: mfl_providerappeals@molinahealthcare.com

Provider Information

- Provider Name: _____
- Provider TIN: _____
- Provider NPI: _____
- Address: _____
- Office Contact Name: _____
- Contact Phone: _____

Member Information

- Member First Name: _____
- Member Last Name: _____
- Member DOB: _____
- Member ID: _____

PCP Dismissal Reason

Please follow instructions as indicated on the Provider Manual related to PCP dismissal: [Provider Manual and Orientation](#)

The Member is not complying with the recommended health care plan.

Provide details: _____

Member behavior is disruptive, unruly, abusive, or uncooperative. This does not apply to Members with mental health diagnosis if the Member's behavior is attributable to the mental illness.

Provide details: _____

Missed Appointments. Members who miss three consecutive appointments within a six-month period may be considered for disenrollment from a provider's panel.

Provide details: _____

Date Verbal Warning given to the Member: _____

Date Written Warning given to the Member: _____

Printed Name:

Date:

Signature: