DAS INTERNAL USE Rcvd Date: _____ DAS Processor ID_____
☐ Y flagged in Opt Out Record
Scan as DT 534

SOUTH DAKOTA
state employee
benefits program
learn. act. thrive.

HEALTH HOME OPT-OUT FORM

Member Name: _____

Member 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

Signature:_____ Date: _____