



State Psychiatric Hospital *Care Select* Disenrollment/Enrollment Form

Facility Name _____

Facility Address _____ City _____ ZIP Code _____

Member Name _____ Member ID # _____

Date of Admission _____

We are requesting that the member below be disenrolled from *Care Select* due to admission to our facility.

Anticipated Length of Stay _____

We are requesting that the member below be re-enrolled into *Care Select* due to discharge from our facility.

Discharge Date _____

Person completing this form _____ Phone _____

Date _____

Fax: 317-238-3120

***Care Select*
P.O. Box 441410
Indianapolis, IN 46244-1410**