NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Health Benefits

Local Health Departments (LHD) must complete and submit this form to the DPH CMHRP Program

Manager and DPH Section Chief and Deputy Director Office to request termination/transition of Care Management for High-Risk Pregnancies (CMHRP) services. All requests must be submitted at least **180 days prior** to the requested effective date of service termination.

Through this request, you are hereby attesting that your Health Department will no longer by eligible to receive CMHRP payments upon the effective date of service transition.

Local Health Department Details	
Requestor Name:	Requestor Title:
Email:	Phone Number:
LHD Name:	Counties Covered:
Local Health Department Address:	Zip Code:
City:	State:
Request Details	
Request Type: ☐Full Transition of Services for All Populations (Select all applicable) ☐Standard Plan Enrollees ☐Tailored Plan Enrollees ☐NC Medicaid Direct Enrollees ☐EBCI Tribal Option Enrollees ☐Other/Uninsured Patients ☐Partial Transition of Services (Select all applicable) ☐Standard Plan Enrollees ☐Tailored Plan Enrollees ☐NC Medicaid Direct Enrollees ☐EBCI Tribal Option Enrollees ☐Other/Uninsured Patients	Request Reason(s): ☐Staffing Issues ☐Financial Hardship ☐Other, please explain
Request Date (Today's Date):	Requested Effective Date:
Transition Details	
Estimated Current Caseload Count:	Has A Coverage Plan Been Identified for Service Delivery Post Termination Date? ☐Yes ☐No
Service Coverage Transition Description (if applicable):	
Health Director Signature:	
Date Signed:	