Date

Beneficiary Name
Address
Address

Dear Medicaid Beneficiary:

The Division of Medicaid has a new program called Mississippi Coordinated Access Network or MississippiCAN. In the MississippiCAN program, you will get your health care through a coordinated care organization (CCO). The CCOs have networks of Medicaid doctors and other providers to take care of your health care needs. (See attached list of doctors and providers included) They have specialists too, if you need one. You will get all of the Medicaid services you get now, and the CCOs offer more. The CCOs have special programs to help take care of diseases like diabetes, high blood pressure, asthma, HIV/AIDS and other things. Look at the flyer in this packet to check it out.

In MississippiCAN, you will have a medical home. Having a Medical Home means you will pick one main doctor that you want to see for your health care. But, first you need to pick the CCO you want to join. To help you pick the CCO you want to join, look for your doctor’s name in each of the provider lists in this packet. If your doctor is in both of the lists, then you may want to pick the CCO that has the most to offer you. Read the sheet in this packet that shows what you have with Medicaid now and about each CCO so you can see what they have to offer. Then, please fill out the enrollment form. Put a check mark by the CCO you want and sign your name. Mail the form back to us in the enclosed postage paid envelope.

You do not have to join the MississippiCAN program. You can keep your Medicaid just like it is now. If you do not want to join, put a check mark by “Opt Out” on the form and sign your name. Mail it back in the enclosed postage paid envelope as soon as you can or you may complete the form at www.medicaid.ms.gov/mscan. If you do not send this form back in 30 days to let us know your choice, a CCO will be picked for you. After you are enrolled, you will have 90 days to pick a different CCO or to opt out of the program.
Please complete all sections and return this form back to the Division of Medicaid (DOM) in the envelope included.

### Section 1 Personal Information

<table>
<thead>
<tr>
<th>MEDICAID NUMBER</th>
<th>You must have Medicaid to participate in this program.</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LAST NAME (Print)</th>
<th>FIRST NAME (Print)</th>
<th>Middle Initial</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address Where You Live</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>County</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mailing Address (If Different)</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
</tr>
</thead>
</table>

| (____)_________________________ | ____/_____/_______ |
| Your Phone Number (If Available) | Your Birthday (mm/dd/yyyy) |

Are You Pregnant *(Check one)*
- Yes
- No

What language is spoken in the home?
- English
- Spanish
- Other: ______________________________________

### Section 2 Coordinated Care Organization *(Please choose one)*

Put a check mark by the Coordinated Care Organization (CCO) you want to take care of your health.

- Magnolia Health Care
- United Health Care
- Opt Out (Do not want to join)

My regular doctor is ____________________________ *(Doctor’s Name)*

Provider number is ____________________________ *(Medicaid, NPI or Identifier)*

### Section 3 Your Signature

I have read and understand the information on this application.

All information I gave on this form is true and correct. I know that if I receive health care from a doctor not in my Plan that I will have to pay.

_____________________________  __________________
Your signature/or witness      DATE

Information that you give is private. Your medical information can only be shared if needed to give medical services. If you receive services under the CCO you give the CCO right to give Medicaid information about your health.