

OPT-OUT FORM

To get your Medicare services through Magellan Complete Care of Arizona, Inc. (HMO SNP), you do not have to do anything.

You will be automatically enrolled on [<insert effective date>](#).

If you **DO NOT** want to get your Medicare benefits through the MCC of AZ (HMO SNP) Plan you must notify us prior to [<insert effective date>](#). You can complete and return this form to us in the enclosed postage paid envelope or you can call us at 1-800-424-4509 (TTY 711) from 8 a.m. to 8 p.m., Monday through Friday (from October 1-March 31, 7 days per week).

Name: _____

Address: _____

City, State, Zip: _____

Phone number: _____

Membership number: _____

Signature: _____ Date: _____

If you are an authorized representative completing this form for one of our members, please provide the following information:

Name: _____

Address: _____

Phone number: _____

Relationship to enrollee _____

Signature: _____ Date: _____

If you have questions, please call MCC of AZ (HMO SNP) at 1-800-424-4509 (TTY 711) from 8 a.m. to 8 p.m., Monday through Friday (from October 1-March 31, 7 days a week).