

PLAN YEAR 2017 PLAN WITHDRAWAL NOTIFICATION REQUEST FORM FOR STATES

This form provides information to the Centers for Medicare & Medicaid Services about Qualified Health Plan (QHP) and/or Stand-alone Dental Plan (SADP) withdrawals requested by states. Please complete and sign this form and submit to CMS_FEPS@cms.hhs.gov with the subject line "QHP State Plan Withdrawal Form".

1. Enter the State Name and Issuer ID(s) affected.

State Name: _____ Issuer ID: _____

2. List plan IDs to be withdrawn. You may also attach a plan list.

3. Describe the specific reason(s) and details related to the withdrawal (e.g., type of pending state regulatory action, including relevant facts; provider network at capacity, including relevant details, etc.). Please indicate whether the issuer has met applicable state requirements (e.g., provided consumer notices).

4. Notify the issuer that this form has been submitted to CMS requesting withdrawal of the plans listed above.

5. Sign the form.

By signing this form, I confirm that the QHP(s) and/or SADP(s) listed above should be withdrawn. I understand that these plans will not be offered in _____ for plan year 2017, and I have notified the issuer that these plans will be withdrawn.
(State)

(Signature)

(Date)

(Print Name)

(Title)