DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

PLAN YEAR 2016 PLAN WITHDRAWAL NOTIFICATION FORM FOR STATES

Please: a. Fill in the fields below.
b. Print, sign, and scan the form OR sign the form electronically.
c. Send the signed form to QHPinfo_states@cms.hhs.gov using the subject line "QHP – State Plan Withdrawal Form."

This form provides information to the Centers for Medicare & Medicaid Services about Qualified Health Plan (QHP) or Stand-Alone Dental Plan (SADP) withdrawals requested by _____.
(State)

_____ requests to withdraw the following Plan IDs (list all impacted Plan IDs in the table below)
(State)
as they are not recommended for certification for Plan Year 2016:

Plan IDs:

Reason(s) for wiithdrawal request:
In the space below, please indicate the reason for which you are requesting to withdraw the Plan IDs listed in the table above.

Signature:

I,_____, confirm that the QHP(s) and/or SADP(s) listed above
(Name of Authorized Representative of State)
should be withdrawn and are not recommended for certification. I confirm that the applicable issuer(s) has been notified.

_____ _____
(Signature) (Date)

_____ _____
(Print Name) (Title)