North Carolina _____________________County Department of Social Services

Voluntary Request to Terminate Medicaid

Case Identifier: ______________
Worker: ______________
Date Generated: ______________

____
Name

____
Address

____

This letter is being mailed to your household because ________________ County Department of Social Services (DSS) has received a verbal request for Medicaid benefits to be terminated. *If you no longer wish to terminate your Medicaid benefits, disregard this letter.*

You, your spouse, and/or your child(ren) may continue to be eligible for Medicaid. If you have questions or need assistance, please contact your Medicaid caseworker at: _________________.

If you wish to terminate your Medicaid benefits, please complete, and sign this form and return it to _________________ County DSS. Your Medicaid benefits will not be terminated without a written request.

Members of the Medicaid household requesting Medicaid termination:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

I understand that I, my spouse, and/or my child(ren) may continue to be eligible for Medicaid. I am requesting that Medicaid benefits be terminated for the Medicaid beneficiaries listed above because:

____
____
____

______________________________ ______________________________
Signature Date

DHB-2050
4/2023