alameda county behavioral health
MENTAL HEALTH & SUBSTANCE USE SERVICES

ALAMEDA COUNTY BEHAVIORAL HEALTH
MENTAL HEALTH PLAN FEE-FOR-SERVICE PROVIDER
DISENROLLMENT REQUEST

Instructions:
Use this form to request voluntary disenrollment as an Alameda County Mental Health Plan Fee-for-Service Provider.

1. Complete the form below
2. Sign and date
3. Submit the completed form to ACBH by:

Email: procurement@acgov.org
Or fax: 510-567-8290
Or mail to:
ACBH Contracts Unit
Attention: Michiko Ronné
1900 Embarcadero Cove, Suite 205
Oakland, CA 94606

Provider Name: _____

I request disenrollment from the Specialty Mental Health Services Agreement
Effective Date: _____

As set forth in my Specialty Mental Health Services Agreement, I understand that contractual obligations require: "*Records shall be retained by Contractor and shall be made available for auditing and inspection for no less than five (5) years following the provision of any services pursuant to this Agreement, or for a longer period as required by the applicable funding source.*"

In the future, ACBH, beneficiaries, and/or their representatives may access medical records by contacting:

Name _____
Mailing Address _____
City, State, ZIP _____
Phone _____

I certify that as a provider/practitioner under contract with ACBH I have documented discharge plans and coordinated continued medical care for all beneficiaries at the time of this disenrollment request.

Signature: _____ Date: _____