**Exhibit 30: Model Notice to Research Potential Out of Area Status – Address Verification Form included**

Referenced in §40.2.1.3

<date>

<Name>

<Address>

<City>, <State> <ZIP>

<Name>:

**IMPORTANT: We need to know where you live**

**If you’ve moved, you may no longer live in <plan>’s service area.** Please provide your new address by <day prior to the disenrollment effective date>.

**How to provide your address**

You need to do one of the following:

1. **Call** <phone>, <days> from <hours>. TTY users should call <TTY number>.
2. **Fill out the “Address Verification Form”** and return it in the enclosed envelope or by fax.

**Your permanent address must be inside <plan>’s service area**

You can be away from <plan>’s service area for up to 6 months in a row and still stay a member of <plan>. If you move and your new address is outside the service area, or if you leave the area for more than 6 months in a row, you’ll be disenrolled from <plan>’s health services and prescription drug coverage. If you’re disenrolled, you’ll be able to join a plan that serves the area where you now live.

**You must tell Social Security about your address change**

If you’ve moved and haven’t told Social Security your new address, call 1-800-772-1213 (Monday to Friday 7am – 7pm). TTY users should call 1-800-325-0778.

**You must also tell your Department of Human Services (DHS) local office caseworker about your address change**

If you’ve moved and haven’t told your caseworker your new address, you can call your local office to report the change or report the change on-line at <http://www.dhs.state.il.us/page.aspx?item=46873>.

**Who should I call if I have questions about <plan>?**

If you have questions, call <plan> Member Services at <toll-free phone number> <days and hours of operation>. TTY users should call <toll-free number>. You can visit <web address>. You can also call Illinois’ Client Enrollment Services at 1-877-912-8880 (TTY: 1-866-565-8576), Monday to Friday from 8 a.m. to 7 p.m. and Saturday from 9 a.m. to 3 p.m. The call is free!

You can get this document in Spanish, or speak with someone about this information in other languages for free. Call [insert Member Service phone and TTY/TDD numbers, and hours of operation]. The call is free. *[The previous sentence must be in English and all non-English languages that meet the Medicare or State thresholds for translation, whichever is most beneficiary friendly. The non-English disclaimer must be placed below the English version and in the same font size as the English version.]*

This information is available for free in other languages and formats like Braille or audio CD.

**Address Verification Form**

|  |  |  |  |
| --- | --- | --- | --- |
| **What is your permanent address?**  **Provide the permanent address where you live. This can’t be a P.O. box.** | | | |
| Address | | | | |
| City | | State | ZIP code | |
| County | Phone | | | |

**Temporary address**

*(You may skip this section if you’re living at your permanent address.)*

|  |  |  |  |
| --- | --- | --- | --- |
| **If you don’t live at your permanent address, what is your temporary address?**  **This can’t be a P.O. box.** | | | |
| Address | | | |
| City | | State | ZIP code |
| County | Phone | | |
| When did you begin living at this address? | When do you think you’ll go back to your permanent address? | | |
| **Where you would like to get your mail?** | | | | |
| Address | | | | |
| City | | State | ZIP code | |

Send us the form in one of two ways:

1. Mail your completed form to <address>.
2. Fax your completed formto <fax number>.

**For more information,** visit <web address>. **If you have questions**, call <plan> at <toll-free number>, <days and hours of operation>. The call is free.