

MSHO Change of NF Liability Status Request

Date:
Sender:
Sender Care System/Health Plan:
Phone: _____ Fax: _____

To: <u>Minnesota Senior Health Options Staff, DHS</u>	Fax: <u>651-431-7450</u>
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Enrollee Name: _____	Enrollee PMI _____
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1. This form is being submitted: ___ to notify that 180 day liability period has ended/will end (verification attached) ___ other:

Comments:
