



## 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: [MHPProviders@acgov.org](mailto:MHPProviders@acgov.org)

Or fax: 510-567-8290

Or mail to:

ACBH Contracts Unit

Attention: Michiko Ronné or Ruby Von Mecklenburg  
1900 Embarcadero Cove, Suite 205 Oakland, CA  
94606

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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: \_\_\_\_\_