Attachment D

TRIBAL HEALTH IMPROVEMENT PROGRAM

MEMBER OPT OUT FORM

I have been notified of my enrollment in the Medicaid Tribal Health Improvement Program and have made an informed decision to opt out of the program. This informed decision was made after a telephone or face-to-face visit with a care coordinator from T-HIP, during which the care coordinator explained the program to me. I have chosen to opt out of the program entirely.

If I decide later that I would like to re-enroll in the program, I can do this by contacting the T-HIP care coordinator or the DPHHS Health Resources Division at the address, phone number, or fax number below.

_____

Name (Print your name on this line)

_____

Signature (sign your name on this line)

_____

Medicaid ID Number

_____

Current Telephone Number

Mail or Fax to the following:

Fax:
(406) 444-1861

Attention:

DPHHS Health Resources Division
IHS/Tribal 638/UIO Section
406-444-4455

Mail:
DPHHS Health Resources Division
IHS/Tribal 638/UIO Section
1400 Broadway, Room A206
P.O. Box 202951
Helena, MT 59620-2951