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.** The care coordinator explained the program and offered me the option of staying in the program in a pending status where I would be able to call the Care Coordinator if I have any questions or if I would like to become more active in the program. I have chosen to opt out of the program entirely.

If I decide at a later time that I would like to re-enroll in the program, I can do this by contacting the T-HIP care coordinator or the State Medicaid Office 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:

IHS/Tribal 638 Program Officer
406-444-4349

Mail:

Hospital and Physician Bureau
1400 Broadway, Room A206
P.O. Box 202951
Helena, MT 59620-2951