TRIBAL HEALTH IMPROVEMENT PROGRAM

MEMBER OPT IN FORM

Previously, I was informed of my enrollment in the Medicaid Tribal Health Improvement Program. At that time, I decided to not participate in the program and chose to opt out. After meeting with a care coordinator from T-HIP (either face-to-face or by telephone) I have made the informed decision to opt back into the T-HIP Program and become an active member in the program.

My opt in status is contingent on meeting Medicaid and program eligibility.

_____

Name (Print your name on this line)

_____

Signature (Sign your name on this line)

_____

Member Date of Birth *Member Medicaid ID*

_____

Current Telephone Number

_____

Member Physical Address

_____

Member Mailing Address

_____

Section to be filled out by T-HIP Care Coordinator:
The T-HIP understands that this member has requested to opt-in to T-HIP services by their own choice. The member's opt-in status is contingent on the above-mentioned criteria, and filling out this form does not guarantee that the member will be eligible to be attributed to the T-HIP.

_____

T-HIP Care Coordinator Signature Date

_____

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