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