Print Clear Form

HEALTH SYSTEMS DIVISION
Member Services

Oregon Health Authority

American Indian / Alaska Native
Oregon Health Plan Enrollment Status Change Request

American Indian or Alaska Native clients: Please use this form to start or end your fee-for-service (FFS or "open-card"), coordinated care organization (CCO) or other enrollment (such as dental plan enrollment).

- Send this completed form to your worker, **or**
- Scan and send the completed form via secure e-mail to hnatribal.requests@state.or.us.

Please allow 2 weeks for processing, or mark the EXPEDITE box for faster processing. To check status, call OHP Customer Service at 1-800-699-9075.

Name: _____
Last First Middle initial

Address: _____
Street or mailing address

_____
City ZIP

Date of birth: _____ Social Security number: _____

Oregon Medicaid ID: _____ *(as shown on your Oregon Health ID)*

I would like to change my current enrollment as follows. *For each service type, mark your current enrollment in the "Change from" box and requested enrollment in the "Change to" box:*

	Change from:		***Change to:***		
Service type	**FFS**	**Enrolled**	**FFS**	**Enrolled**	**CCO/plan name**
Medical	☐	☐	☐	☐	_____
Dental	☐	☐	☐	☐	_____
Mental health	☐	☐	☐	☐	_____

☐ **PLEASE EXPEDITE** – *Check this box for urgent requests that require faster processing*

_____ _____
Signature of Client or Client Representative - *Representative must have proof of legal authority to sign for this client* Date

Relationship of Client Representative to Client: _____ Phone: _____