Michigan Department of Community Health

NATIVE AMERICAN REQUEST FOR EXCEPTION FROM MANAGED CARE

For MDCH Office Use Only
Contact No.
Date Processed

INSTRUCTIONS:

- Complete Section 1 of this form.
- You MUST attach proof of Tribal Membership. *(See item 6 below)*
- If non-tribal members are requesting an exception, complete Section 2 of this form.

When complete, mail or fax this form to:

ENROLLMENT SERVICES SECTION
MEDICAL SERVICES ADMINISTRATION
PO BOX 30470
LANSING MI 48909
FAX: (517) 373-1437

SECTION 1 - Family / Case Information:

1. Family Address (number and Street)			4. Home Telephone Number
2. City	**MI**	3. ZIP Code	5. DHS Case Number (optional)

6. Check which Proof of Tribal Membership you have attached. ***(Do not send an original form. Send a photocopy only)***

☐ **Tribal Identification Card and / or Picture ID with Tribal Identification.**

☐ **Bureau of Indian Affairs (BIA) Form Acknowledgment and / or Letter Verifying Recognition as Native American.**

☐ **Tribal Enrollment form.** ☐ **Signature of Tribal Chairman or Designee.** ***(See Item 16 below)***

7. ENTER **ONLY** THE NAMES OF FAMILY MEMBERS WHO ARE REQUESTING AN EXCEPTION FROM MANAGED CARE	8. ENTER EACH MEMBER'S BENEFICIARY ID NUMBER	9. DATE OF BIRTH

10. Is your Family Currently Enrolled in a HEALTH PLAN? ☐ **NO** ☐ **YES** ➔ ➔	11. If YES, what is the **Name of your current Health Plan?**

I verify that the above information is true and complete to the best of my knowledge.	14. Beneficiary / Authorized Representative Signature	16. Date Completed
	15. Relationship to Beneficiary	

SECTION 2 - To be Completed by Tribal Chairman or Designee:

Needed only if non-enrolled members are requesting an exception.

I verify that family and family members named above are affiliated with this tribe.	17. Signature of Tribal Chairman or Designee	18. Date Signed

Authority: Title XIX of the Social Security Act
Completion: Is Voluntary, but is required if an Exception is sought.

The Michigan Department of Community Health is an equal opportunity employer, services and programs provider.