Medi-Cal Managed Care
Non-Medical Exemption

Excepción Por Razones No Médicas
Para Atención Médica Administrada de Medi-Cal

Request for Non-Medical Exemption from Plan Enrollment
Indian Health Program Exemption

Each area of the Indian Health Program Exemption form must be completed or the form will be returned unprocessed.

Please Print or Type (Ink Only)

Dear Indian Health Service Facility: If you currently provide or will be providing medical services to an individual who is receiving Medi-Cal benefits and that individual is required to enroll in a health plan, completion of this form will enable the individual to receive services through your facility as an alternative to enrollment in a Medi-Cal Managed Care health plan. The Indian Health Exemption is valid until the individual chooses to enroll in a Medi-Cal Managed Care health plan.

1. Beneficiary Name Last Name First Name M.I.	2. Beneficiary Medi-Cal I.D. Number (BIC) __ __ __ __ __ __ __ __ __ __
3. Name of Indian Health Facility I certify that the information I have provided on this form is correct. I understand that the Department of Health Care Services may audit this form to determine if the information provided is accurate.	
4a. Authorized signature of Medi-Cal Provider	4b. Date signed __ __ Month __ __ Day __ __ Year
4c. Printed name of Medi-Cal Provider Last Name First Name M.I.	4d. Medi-Cal Provider Number **used to bill the Medi-Cal Program for this beneficiary**. __ __ __ __ __ __ __ __ __
5. Telephone number of Medical Provider (__ __ __) __ __ __ — __ __ __ __	6. Fax number of Medical Provider (__ __ __) __ __ __ — __ __ __ __
7. Telephone number of Medical Physician (__ __ __) __ __ __ — __ __ __ __	8. Fax number of Medical Physician (__ __ __) __ __ __ — __ __ __ __

Dear Medi-Cal Beneficiary: If you or a family member is receiving Medi-Cal benefits, you may be required to join a Medi-Cal Managed Care health plan. However, if you or a family member is a Native American, Alaskan Native or qualified non-Indian and you want to receive medical services through an Indian Health Service (IHS) facility, you may request to be excused from Medi-Cal Managed Care health plan enrollment in order to receive services through an Indian Health Service facility.

To be excused from plan enrollment you must have an Indian Health Service facility representative complete this form, certifying that you are or will be receiving services from an Indian Health Service facility. The facility representative must submit this completed form to the HCO program.

Mail completed form to:

Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

or Fax this form to: (916) 364-0287

If you have any questions regarding this form, please call HCO at 1-800-430-4263; TDD/TTY users, call 1-800-430-7077

Estimado beneficiario de Medi-Cal: Si usted o un miembro de su familia está recibiendo beneficios de Medi-Cal, es posible que deba inscribirse en un Plan de Salud Administrado de Medi-Cal. Sin embargo, si usted o un miembro du su familia es de origen Indígena Americano, Nativo de Alaska o reúne los requisitos para personas de origen no indígena y desea recibir servicios medícos a través de un centro de Indian Health Service (IHS), puede solicitar que esté excluido de inscribirse en un plan de salud de Atención Médica Administrada de Medi-Cal para recibir los servicios a través del centro de Indian Health Service.

Para que esté excluido de inscribirse en el plan, debe solicitarle a un representante del centro de Indian Health Services que llene este formulario, en el que certifica que usted recibe o recibirá servicios a través de un centro de Indian Health Service. El representante del centro debe enviar este formulario completo al programa HCO.