

American Indian / Alaska Native Health Plan Disenrollment

Name _____
Last First Middle Initial

Address _____

City _____ ZIP _____

Date of Birth _____ Social Security # _____

Prime # _____ (Shown on your DMAP Medical Care ID)

I would like to disenroll from my current OHP managed care plan.

Medical Dental Mental Health

I have already sent my proof of status as an American Indian/Alaska Native.

I am sending my proof of status as an American Indian/Alaska Native with this form.

Signature _____ Date _____

Return completed form to:

HMU/DMAP
500 Summer Street NE, E44
Salem, OR 97301-1079
Phone: 503-945-5796
Fax: 503-947-5221
Email: dmap.hmu@state.or.us
(HMU, DMAP in GroupWise)