Tribal Health

CONFEDERATED SALISH AND KOOTENAI TRIBES

APPLICATION FOR TRIBAL HEALTH PAID CARE

Name:_____ **DOB:**_____

Physical Address: _____

_____

Confirmed by:_____ (Please attach copies of documentation)

TRIBAL AFFILIATION:

_____ CSKT Enrolled Member

_____ CSKT Descendant

_____ Other Federally Recognized Enrolled Member

_____ Other Federally Recognized Descendant

_____ Other

INSURANCE INFORMATION:

Medicaid/Healthy Montana Kids: Yes No **Veteran Healthcare Benefits: Yes No**

Medicare: Part A Part B Part C Part D

Private Insurance: _____

Insurance Policy #:_____

Policy Holder Name:_____ **Policy Holder Birthdate:**_____

Policy Holder Relationship: Self_____ **Spouse**_____ **Child**_____ **Other**_____

Coverage eligibility date:_____

Primary Care Provider:_____

Specialist (such as R/A; OB/GYN):_____

Office Use Only

HR# _____ Residency Confirmed_____

Resides On Reservation:_____ Resides Within County: Flathead / Lake / Missoula / Sanders

Resides Outside of Service Area_____

FRAUD STATEMENT:

By signing below, I acknowledge that I have provided true and correct answers to all the questions on this form to the best of my knowledge. I also understand and know that I may be subject to penalties if I intentionally provide false information.

ASSIGNMENT OF BENEFITS (AOB):

I understand that CSKT Tribal Health has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. This AOB authorization is in effect until revoked by patient in writing. Further, I understand that Tribal Health may bring a claim or cause of action against the third party for recovery of such medical expenses.

Therefore I agree as follows:

1. To assign to Tribal Health any claim of cause of action against the third person to the extent of the medical expenses paid, or any portion thereof;
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted by or against a third party;
3. To notify Tribal Health of a settlement with, or an offer of settlement, for myself or my dependents;
4. The AOB authorization is in effect until revoked by Recipient.

I authorize Tribal Health to furnish information carriers and other third party payers concerning my illness and treatment, and herby assign all payments for medical services rendered to myself or my dependents.

AUTHORIZATION TO RELEASE INFORMATION:

I hereby authorize CSKT Tribal Health to release any information necessary to insurance carriers regarding my diagnosis and treatments for services received, to process claims or for the purpose of making a determination on a paid care request. A photo copy of my signature may be used for these purposes until such time I revoke authorization.

SIGNATURE of Applicant

_____

Name

_____

Date

SIGNATURE of Tribal Health Authorized Representative

_____

Name

_____

Date