

SOKAOGON CHIPPEWA PURCHASED REFERRED CARE AND MEDICARE RELIEF BLOCK GRANT APPLICATIONS

FOR OFFICE USE ONLY		
DATE OF APPROVAL		
MA	DENIAL <input type="checkbox"/>	ACCEPTANCE <input type="checkbox"/>
PRC	DENIAL <input type="checkbox"/>	ACCEPTANCE <input type="checkbox"/>
MRBG	DENIAL <input type="checkbox"/>	ACCEPTANCE <input type="checkbox"/>
OTHER COVERAGE	YES <input type="checkbox"/>	NO <input type="checkbox"/>
APPLICANT(S) DENIED, SPECIFY REASON:		

SECTION A - APPLICANT							
LAST NAME (Head)		FIRST NAME		MIDDLE NAME (Complete)		MAIDEN NAME	
ADDRESS		CITY		STATE	ZIP CODE	COUNTY	
MAILING ADDRESS							
HR#	BIRTH DATE		SOCIAL SECURITY NUMBER			MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
ENROLLED SOKAOGON? YES <input type="checkbox"/> NO <input type="checkbox"/>		ARE YOU A VETERAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		IS YOUR EMERGENCY CONTACT PERSON YOUR SPOUSE WHO WILL BE LISTED BELOW? IF YES, CONTINUE TO SECTION B IF NO, CONTINUE TO NEXT LINE			
EMERGENCY CONTACT - NAME			RELATIONSHIP			PHONE	
ADDRESS			CITY		STATE	ZIP CODE	
SECTION B - APPLICANT'S SPOUSE							
LAST NAME (Spouse)		FIRST NAME		MIDDLE NAME (Complete)		MAIDEN NAME	
ADDRESS		CITY		STATE	ZIP CODE	COUNTY	
MAILING ADDRESS							
HR#	BIRTH DATE		SOCIAL SECURITY NUMBER			MALE <input type="checkbox"/>	FEMALE <input type="checkbox"/>
ENROLLED SOKAOGON? YES <input type="checkbox"/> NO <input type="checkbox"/>		ARE YOU A VETERAN? YES <input type="checkbox"/> NO <input type="checkbox"/>		IS YOUR EMERGENCY CONTACT PERSON YOUR SPOUSE LISTED ABOVE? IF YES, CONTINUE TO SECTION C IF NO, CONTINUE TO NEXT LINE			
EMERGENCY CONTACT - NAME			RELATIONSHIP			PHONE	
ADDRESS			CITY		STATE	ZIP CODE	
SECTION C - APPLICANT'S CHILDREN UNDER 18 (Living at the above address)							
LAST NAME (Complete)	FIRST NAME	MIDDLE	SEX	BIRTH DATE	SOCIAL SECURITY #	✓ IF ENROLLED	HR#'S
SECTION D - OTHER MEDICAL COVERAGE							
INSURANCE OR MEDICAL COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>			EMPLOYER NAME				
INSURANCE NAME			POLICY/GROUP#		PLEASE ATTACH COPIES OF ALL INSURANCE/OTHER COVERAGE CARD(S) (FRONT AND BACK)		
INSURANCE NAME			POLICY/GROUP#				
PRESCRIPTION COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>			DENTAL COVERAGE? YES <input type="checkbox"/> NO <input type="checkbox"/>				
MEDICAL ASSISTANCE (WI)? YES <input type="checkbox"/> NO <input type="checkbox"/>			MEDICARE (SOCIAL SECURITY)? YES <input type="checkbox"/> NO <input type="checkbox"/>				
SECTION E - SIGNATURE							
I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND UNDERSTAND THAT IT IS MY RESPONSIBILITY AND OBLIGATION TO NOTIFY THE SOKAOGON CHIPPEWA HEALTH CLINIC PURCHASED REFERRED CARE PROGRAM OF ANY CHANGE IN THE ABOVE INFORMATION WITHIN 30 DAYS OR HEALTH BENEFITS MAY BE DENIED.							
APPLICANT SIGNATURE						DATE	

• APPLICATION MUST BE UPDATED ONCE PER YEAR • ALLOW 30 DAYS FOR PROCESSING



Sokaogon Chippewa Health Clinic

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www.sokaogonchippewa.com



SOKAOGON CHIPPEWA MEDICAL INFORMATION RELEASE FORM

I hereby give the Sokaogon Chippewa Health Clinic Purchased Referred Care Program authorization to request medical records regarding myself and/or family members from our health care provider. This will streamline claims processing. All information received will be confidential under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This release is valid for one year from the date signed below.

HOUSEHOLD TRIBAL MEMBERS OVER 18 MUST SIGN BELOW

SIGNATURE: _____

DATE: _____

SIGNATURE: _____

DATE: _____

BY CHECKING AND PROVIDING THE INFORMATION BELOW, I GIVE PERMISSION TO CONTACT ME VIA:

- MAIL
- CELL PHONE: _____
- E-MAIL: _____

PLEASE ATTACH COPIES OF ALL INSURANCE/OTHER COVERAGE CARD(S) (FRONT AND BACK)

Ga-na-waji Ga-wi-nug Way-ji-mooki-ji-wung Yi-ewe-meing-gun-a-sepii