Tribal Health CONFEDERATED SALISH AND KOOTENAI TRIBES

APPLICATION FOR SERVICE

Confederated Salish & Kootenai Tribes
PO Box 880 St. Ignatius, MT 59865
Ph (406) 745-3525 Fax (406)745-4719

RECIPIENT INFORMATION

_____ _____ _____
First Name Middle Initial Last Name Birthdate Age

Social Security #:_____ Veteran: Yes No Gender: Female Male

Tribal Affiliation:_____ Enrollment #:_____
Tribal Descendant: Yes No Verification Attached: Yes No

_____
Mailing Address City State Zip

_____
Physical Address City State Zip

_____ _____ _____
Primary Phone Work Phone Message Phone

Email:_____ Permission to send Tribal Health updates: Yes No

Please designate a Primary Care Provider (PCP):_____

_____
Emergency Contact: Name Relationship Phone

INSURANCE INFORMATION

If available, please provide proof of insurance.

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

Medicare: Part A Part B Part C Part D

Private Insurance:_____ _____
Name of Insurance Policy #

Policy Holder:_____ Date of Birth:_____ Relationship:_____

**********OFFICE USE ONLY**********

Date record Established / Updated:_____ By: _____

Referred to Health Care Resources (HCR) Technician:_____ Date: _____

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RECIPIENT NAME:_____

RECIPIENT PRIVACY RIGHTS (Public Law 93-579) I understand that the information given by me and/or collected is necessary for Tribal Health to provide for my well being. Furthermore I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

ASSIGNMENT OF BENEFITS (AOB) I understand Tribal Health (TH) 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 party 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 hereby authorize Tribal Health to furnish information to insurance carriers and other third party payers concerning my illness and treatment, and hereby assign all payments for medical services rendered to myself or my dependents.

RELEASE OF INFORMATION

I authorize Tribal Health to collect information on behalf of myself and my dependents. I understand that information received by Tribal Health will be kept confidential, and used for professional purposes only in terms of facilitating services for me and my dependents. I acknowledge that Tribal Health is the **PAYER OF LAST RESORT**, and therefore **I must apply for and accept all medical benefits and/or alternate resource coverage when available.**

CONSENT TO SERVICES

Recipient hereby consents to any services provided in connection with Recipient's treatment by Tribal Health (TH) health service providers and by independent health service providers affiliated with TH. These services may include, but are not limited to, inpatient, outpatient, and/or emergency services; diagnostic procedures; transportation; nursing care; and other healthcare services provided to Recipient upon the instructions of Recipient's providers. "Recipient acknowledges that no guarantees have been made regarding the outcome of these services. If Recipient is unable to sign, consent for treatment: (1) is hereby given by representative(s) authorized to make decisions and sign this agreement on Recipient's behalf, or (2) in cases of emergency, shall be implied. The term "TH" includes the health care service providers owned or controlled by Tribal Health.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty for each violation.

_____ _____

Signature of Applicant **Date**

_____

Signature of Legal Representative , if other than Applicant

_____

Printed Name