COWLITZ INDIAN TRIBE

Data Entry ______
Verified ________
HRN __________

HEALTH SERVICES
PURCHASE REFERRED CARE
INSURANCE UPDATE FORM

DEMOGRAPHIC INFORMATION

Legal Name:____ DOB: ________________________
Preferred Name: ____
Physical Address:____
Mailing Address: ____ ☐Unsheltered ☐No Fixed Address
County: ____
Phone: ___________________________________ Permission to Leave Voice Mail/Text: ☐Yes ☐ No
Message Phone: ____________________________ Email Address: ____________________________
Emergency Contact:________________________ Phone: ______________________________________

FEDERAL/STATE

Medicare Part A ☐ Part B ☐ ID#: ____

Medicare Advantage/Supplement Plan Name: ___________________________ ID#:___________________
Dental Ins. Name/ID#:________________________ **Optical Ins. Name/ID#:**_ ________________________
Hearing Ins. Name/ID#: ____

Medicaid ID#: _________________________________ Eff. Date: ______________________________
Medicaid Managed Care Plan Name: __________________________________ ID#: ___________________

ALL OTHER

1) **Medical Insurance** ____
ID#:____________________GRP#:_________________ RX Policy Name & ID# :____________________
Dental Ins. Name/ID#:______________________ **Optical Ins. Name/ID#** _______________________
☐ Employer Sponsored Plan OR ☐ Purchased Through the Health Plan Finder
Policy Holder Name: ______________________ ☐Self ☐Spouse ☐Parent ☐Other: ______________
Employer Name:____ Phone: ________________________

☐ **I Have NO Other Insurance** (CHECK this box and skip to the back page)

2) **Medical Insurance** ____
ID#:____________________GRP#:_________________ RX Policy Name & ID# :____________________
Dental Ins. Name/ID#:______________________ **Optical Ins. Name/ID#** _______________________
☐ Employer Sponsored Plan OR ☐ Purchased Through the Health Plan Finder
Policy Holder Name: _______________________ ☐Self ☐Spouse ☐Parent ☐Other: ______________
Employer Name:____ Phone: ________________________

Name and date of birth of other Tribal Members in your household:

____

AUTHORIZATIONS

SCAN TO VIEW BOTH

_______Initial here confirming you have received or were offered a copy of the Notice of Privacy Practice

_______ Initial here confirming you have received or were offered a copy of the Patient's Rights and Responsibilities

_______Initial here to consent to receive information related to treatment, payment, or health care operations, including receiving autodialed and prerecorded message calls and/or text messages at all telephone numbers provided, or, if not current, to any number you may reasonably be associated with.

_______Initial here confirming you have been notified that most laboratory services will be performed and billed by a facility outside of the Cowlitz Indian Tribe (CIT) and you understand that you and/or your insurance provider(s) are responsible for costs associated with these services.

_______Initial here confirming the following (**Cowlitz Tribal Members only**): I understand 42 CFR 136.23 mandates that I provide true and accurate information used to make an eligibility determination prior to approval of federal funds being expended on my behalf through the Purchase Referred Care (PRC) program. I understand that information provided on my application may be verified to ensure compliance with federal law and the Cowlitz Indian Tribe's Self Governance agreement. I understand that providing false or incomplete information could result in non-compliance with federal regulations, and to the best of my knowledge, I attest to the accuracy of the information I have provided. I understand 42 CFR 136.61 mandates that PRC is a payor of last resort and that I am required to apply for and utilize all other resources available to me. If I am un-insured or underinsured, I will be required to apply for alternate resources available to me and may only decline if there is a cost associated with accepting coverage. I am aware that as a CIT Member I must maintain residency in the Tribe's designated service delivery area to access PRC. If I relocate, I must notify the PRC program of my new residence. If I relocate to attend college and maintain status as a full-time student, I may remain eligible for PRC while in attendance. I am aware that demographic information such as my address and phone number may be shared with the CIT Enrollment Department when appropriate.

ALL CLIENTS/PATIENTS: My signature indicates, to the best of my knowledge, that all information provided is true and accurate. My signature authorizes the release of medical information necessary for diagnosis, treatment, and billing. I hereby authorize billing and payment of services, assign benefits otherwise payable to me to CIT, and request that payments be made to CIT directly. I agree to remit to CIT any payment sent directly to me for services provided by CIT.

☐ **Provided with my registration are copies FRONT & BACK of all insurance cards.**

Print Name:____ **Relationship:**______________________________

Signature: ____ **Date:** ___________________________________