Ho-Chunk Nation Health Department
Purchased Referred Care

M E M O R A N D U M

TO: _____

FROM: Sarah Decorah, Patient Registration/Billing Manager

DATE: _____

RE: Purchased/Referred Care Coverage Update or Application

Enclosed is a blank Purchased/Referred Care application and medical information release form to be completed and returned, be sure to include all members in your immediate family under the age of 18 years old.

The Purchased/Referred Care Program requires a yearly update and also an update whenever reported information changes. If upon review of your application you are found to be eligible, the application will be approved and you will be notified by mail.

Required information to be remitted with the application is as follows:

1) copies of all income received in the household;
2) copies of any insurance and/or medical coverage;
3) dental and/or prescription coverage information;
4) require to apply for ACA (Marketplace) if no insurance available or if you don't have insurance.(Bronze Plan);
5) birth dates and social security numbers;
6) require physical address verification; and
7) copies of enrollment verification for all enrolled.

NOTE: IF ANY OF THE ABOVE INFORMATION IS NOT INCLUDED, A LETTER WILL BE SENT INFORMING YOU OF ADDITIONAL INFORMATION NEEDED; YOUR APPLICATION WILL NOT BE APPROVED UNTIL ALL REQUIRED INFORMATION IS RECEIVED.

Purchased/Referred Care is the "payer of last resort" and, under our contract, is required to verify eligibility for alternate resources of medical coverage. The above information is used to determine whether you are eligible for other coverage and/or programs.

You may return the completed application along with the required documentation to:

Ho-Chunk Nation
Purchased/Referred Care
P.O. Box 636
Black River Falls, WI 54615

PLEASE RETURN YOUR APPLICATION WITHIN 30 DAYS OR YOU WILL NO LONGER BE CONSIDERED FOR COVERAGE.

cc: File

M-UP122916

Ho-Chunk Health Care Clinic
P.O. Box 636 • N-6520 Lumberjack Guy Road
Black River Falls, WI 54615
Phone (715) 284-9851 • Fax (715) 284-0100

Ho-Chunk Nation Purchased/Referred Care

P.O. Box 636 • Black River Falls, WI 54615

APPLICATION

• PLEASE PRINT CLEARLY •

FOR OFFICE USE ONLY

Date of Approval _____

Date Approval Mailed _____

Verification of Income _____

Other Coverage _____

APPLICANT(S) DENIED, SPECIFY REASON:

LAST NAME (Head)	FIRST NAME	MIDDLE (Complete)	MAIDEN	Social Security#	Birth Date	Sex M F

IHS Code#	Enrolled Ho-Chunk? Yes No	Blood Quantum	Other Tribal Affiliation (Specify)	Enrolled? Yes No	Blood Quantum	Telephone# ( )

Address (Number and Street)	City	State	Zip	Mailing Address	County

Father's Name	City of Birth	State	Mother's Maiden Name	City of Birth	State

Are You a Veteran? Y N	Emergency Contact - Name	Phone Number	Relationship	Address

LAST NAME (Spouse)	FIRST NAME	MIDDLE (Complete)	MAIDEN	Social Security#	Birth Date	Sex M F

IHS Code#	Enrolled Ho-Chunk? Yes No	Blood Quantum	Other Tribal Affiliation (Specify)	Enrolled? Yes No	Blood Quantum	Telephone# ( )

Father's Name	City of Birth	State	Mother's Maiden Name	City of Birth	State

Are You a Veteran? Y N	Emergency Contact - Name	Phone Number	Relationship	Address

CHILDREN UNDER 18 (Living at above Address)

Last Name	First	Middle (Complete)	Sex	Birth Date	Social Security#	✓ If Enrolled	IHS Code#

INCOME SOURCE	HEAD	SPOUSE
Gross Pay (Weekly / Bi-Weekly / Monthly)	$	$
Veteran's Benefits / Social Security / Supplemental Security Income	$	$
Unemployment / Disability / Workman's Compensation / Per Capita	$	$

PLEASE **ATTACH** COPIES OF ALL INCOME RECEIVED IN THE HOUSEHOLD (EXCLUDE PER CAP)

TOTAL MONTHLY INCOME FROM ALL SOURCES $ _____

INSURANCE OR MEDICAL COVERAGE? Yes ____ No ____ **EMPLOYER NAME**_____

INSURANCE NAME _____ POLICY / GROUP# _____

INSURANCE NAME _____ POLICY / GROUP# _____

PRESCRIPTION COVERAGE? ..... Yes ____ No ____ DENTAL COVERAGE? ..... Yes ____ No ____

MEDICAL ASSISTANCE (State)? ..... Yes ____ No ____ MEDICARE (Social Security)? Yes ____ No ____

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

I certify that the above information is correct and understand that it is my responsibility and obligation to NOTIFY THE HO-CHUNK NATION PURCHASED/REFERRED CARE 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

HO-CHUNK NATION
PURCHASED/REFERRED CARE

MEDICAL INFORMATION RELEASE FORM

I hereby give the Ho-Chunk Nation Purchased/Referred Care Program authorization to request medical records regarding myself and/or family members from our health care provider. This will assist in determining the amount of coverage for service(s) provided. All information received will be confidential under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). This release will be valid for one year from the date signed below.

HOUSEHOLD TRIBAL MEMBER NAME(S)	BIRTH DATE(S)
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____
• _____	_____

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:** _____