Ho-Chunk Nation Health Department
Purchased/Referred Care

M E M O R A N D U M

TO:

FROM: PRC Patient Registration/Billing Manager

DATE:

RE: Purchased/Referred Care Coverage Update

Enclosed is a blank Purchased/Referred Care (PRC) application and Authorization for Release of Information 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 an annual update and must notified when 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.

Submit items listed below with application:

1) Copies of all household income;
2) Copies of medical, dental, prescription, insurance cards*;
3) If you don't have insurance then you are required to meet with a benefit specialist;
4) Copies of enrollment verification for all enrolled; and,
5) Physical address verification*.

*For the ones that are just updating please only submit number 2 and 5

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 Center
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 _____
Primary of Coverage _____
Secondary of 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	Veteran Y N

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

Telephone# ( )	Emergency Contact - Name	Phone Number	Relationship	Address

LAST NAME (Spouse/Other)	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	Veteran Y N

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

Telephone# ( )	Emergency Contact - Name	Phone Number	Relationship	Address

CHILDREN UNDER 17 (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 _____

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

PRC AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize the **Purchased Referred Care (PRC) Program**
(Print Name)

Staff to receive confidential health information related to health care and financing for the individuals listed below:

(Print Name)	(Social Security Number)	(Date of Birth)
(Print Name)	(Social Security Number)	(Date of Birth)
(Print Name)	(Social Security Number)	(Date of Birth)
(Print Name)	(Social Security Number)	(Date of Birth)
(Print Name)	(Social Security Number)	(Date of Birth)
(Print Name)	(Social Security Number)	(Date of Birth)

From any person, health care provider, hospital, other health care facility, governmental agency, corporation or other health organization.

Information to be released includes applications, records, reports, assessments, evaluations, and other related information for the purpose of further medical care/insurance application/payment of insurance claims/disability determination/legal investigation/public program eligibility or other:

_____
(Please Specify)

I understand this Authorization is subject to revocation by me at any time. I also understand that a photocopy of this Authorization has the same effect as the original.

I am the Individual named/Parent/Guardian/Conservator for which Authorization is given.

This Authorization for Release of Information expires one (1) year from the date on which it is signed.

_____
Print Name of Individual giving Authorization

_____ _____ _____
Signature of Individual giving Authorization | Relationship to person(s) | Date

BY CHECKING AND/OR PROVIDING THE INFORMATION BELOW, YOU GIVE PERMISSION TO THE PURCHASED REFERRED CARE STAFF TO CONTACT YOU VIA:

☐ MAIL

☐ CELL PHONE: _____

☐ EMAIL: _____