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

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 of your immediate family under the age of 18 years old.

The Purchased/Referred Care Program requires an Annual Update and must be notified when reported information changes. If upon review of your application you are found to be eligible, application will be approved and you will be notified by mail.

Applicants must submit the items listed below (1-5) with the application:

1) Copies of all household income;
2) Copies of medical, dental and 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 (new applicants);
5) Physical address verification (i.e. Drivers License, Wis ID, utility bill, or lease agreement).

***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 and dental 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
N6520 Lumberjack Guy Rd
Black River Falls, WI 54615

PRC@ho-chunk.com

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

cc: File

revised.102824

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

ALL BOXES MUST BE COMPLETED OR
YOUR APPLICATION WILL BE RETURNED
• PLEASE PRINT CLEARLY •

FOR OFFICE USE ONLY
Date of Approval _____
Primary Insurance _____
Secondary Insurance _____
Other coverage _____
Applicant(s) Denied: _____
_____

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

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

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

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

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

LAST NAME (Spouse/Other)	FIRST NAME	MIDDLE (Complete)	MAIDEN	Social Security #	Birth Date	Sex

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

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

Telephone # (Spouse/Other)	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/OTHER
Gross Pay (Weekly / Bi-Weekly / Monthly)	$	$
Veteran's Benefits / Social Security / Supplemental Security Income	$	$
Unemployment / Disability / Workman's Compensation / Per Capita	$	$

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

TOTAL MONTHLY INCOME FROM ALL SOURCES $ _____

INSURANCE OR MEDICAL COVERAGE? Yes ◯ No ◯

PRIMARY INSURANCE _____

SECONDARY INSURANCE _____

PRESCRIPTION COVERAGE? ..... Yes ◯ No ◯

MEDICAL ASSISTANCE / BADGER CARE? Yes ◯ No ◯

EMPLOYER _____

DEPARTMENT _____

WORK PHONE _____

DENTAL COVERAGE? ..... Yes ◯ No ◯

MEDICARE (Check all that apply) A _ _ B _ _ C _ _ D _ _

PLEASE **INCLUDE** 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 to NOTIFY THE PURCHASED REFERRED CARE PROGRAM OF ANY CHANGE IN THE ABOVE INFORMATION WITHIN 30 DAYS or my PRC benefits may be termed or denied.

APPLICANT SIGNATURE _____ **DATE** _____

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

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ authorize the **Purchased Referred Care (PRC) Program**
(Print Name)
Staff and its Providers to receive any information related to health care and financing for the individuals listed below:

_____	_____	_____
(self)	(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)
_____	_____	_____
(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 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**: _____

☐ **E-MAIL:** _____