Oneida Tribe of Indians
Purchased/Referred Care Application

NAME _____ M/R# _____
(Last) (First) (M.I.) (Medical Record Number)

ADDRESS _____ **COUNTY** _____

_____ **HOME PHONE** _____

BIRTH DATE _____ **CELL PHONE** _____

TRIBE _____ **ROLL #** _____

SPOUSE'S INFORMATION

NAME _____ M/R# _____
(Last) (First) (M.I.) (Medical Record Number)

ADDRESS _____ **COUNTY** _____

_____ **HOME PHONE** _____

BIRTH DATE _____ **CELL PHONE** _____

TRIBE _____ **ROLL #** _____

ALL HOUSEHOLD MEMBERS AND YOUR RELATIONSHIP TO THEM

FULL NAME	SEX	D.O.B.	RELATIONSHIP	
				M/R#
				M/R#
				M/R#
				M/R#
				M/R#
				M/R#

EMPLOYMENT INFORMATION

EMPLOYER _____ **PHONE** _____

JOB TITLE _____

SPOUSE'S EMPLOYER _____ **PHONE** _____

JOB TITLE _____

PRIMARY INSURANCE INFORMATION

POLICY NAME _____ ID #_____ GROUP#_____

POLICY HOLDER NAME _____

COVERAGE TYPE: COVERAGE PLAN: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ RX

HMO POLICY IN NETWORK PROVIDER _____ EFF DATE_____

PPO POLICY IN NETWORK PROVIDER _____ EFF DATE_____

SECONDARY INSURANCE INFORMATION

POLICY NAME _____ ID #_____ GROUP#_____

POLICY HOLDER NAME _____

COVERAGE TYPE: COVERAGE PLAN: ☐ MEDICAL ☐ DENTAL ☐ VISION ☐ RX

HMO POLICY IN NETWORK PROVIDER _____ EFF DATE_____

PPO POLICY IN NETWORK PROVIDER _____ EFF DATE_____

WHO HAS THE FOLLOWING COVERAGE?

MEDICARE WHO HAS MEDICARE? ○ A ○ B ○ D

SSI WHO HAS SSI?_____

VETERANS WHO HAS BENEFITS?_____

I understand that there are strict residency requirements regarding the provision of Purchased/Referred Care Services and I hereby affirm that the address listed on this form is my true and correct address. I further agree that it is my sole responsibility to inform the Purchased/Referred Care Department at the Oneida Comprehensive Health Division immediately if my address changes. I understand and agree that I will not be eligible for Purchased/Referred Care Services if I do not meet all requirements, including residency requirements.

I understand that if I receive any insurance benefits meant to cover services or goods provided to me, I am required to reimburse Oneida Purchased/Referred Care for expenditures they make in my behalf.

I hereby authorize the Purchased/Referred Care Specialist to contact other agencies to obtain information that is necessary to further enhance my eligibility. I also acknowledge that I have received the Purchased/Referred Care Brochure & HIPAA Form.

SIGNATURE OF APPLICANT_____ DATE_____

To be completed by staff only

PRC SPECIALIST INITIALS: _____ DATE RECEIVED: _____

TRIBAL ID: YES/NO PROOF OF RESIDENCY: YES/NO DENTAL ONLY: YES/NO

PRC BROCHURE/HIPPA: YES/NO PRC ELIG: YES/NO PRC ELIG DATE: _____