Oneida Comprehensive Health Division
Purchased/Referred Care Application

Email ohc_prc_services@oneidanation.org
Fax 920-869-1782

******Proof of Residency Must be submitted with all applications or will be considered incomplete******

APPLICANT (eligible household member)

NAME ______________________________ **M/R#**______________

ADDRESS ______________________________ **COUNTY**______________

______________________________ **HOME PHONE**______________
(City) (State) (Zip Code)

BIRTH DATE ______________________ **CELL PHONE**______________

TRIBE ______________________ **ROLL #** ______________

SPOUSE'S INFORMATION

NAME ______________________________ **M/R#**______________

BIRTH DATE ______________________ **CELL PHONE**______________

TRIBE ______________________ **ROLL #** ______________

OTHER HOUSEHOLD MEMBERS OR DEPENDENTS

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

APPLICANT EMPLOYER & INSURANCE

APPLICANT EMPLOYER ______________________________ PHONE NUMBER ______________

INSURANCE CARRIER ____

POLICY ID #______________________ GROUP# ______________________

COVERAGE TYPE: **SINGLE** or **SINGLE+1** or **FAMILY** COVERAGE PLAN: **MEDICAL/DENTAL/VISION/RX**

SPOUSE'S EMPLOYER & INSURANCE

SPOUSE EMPLOYER ______________________________ PHONE NUMBER ______________

INSURANCE CARRIER ____

POLICY ID # ______________________ GROUP# ______________________

COVERAGE TYPE: **SINGLE** or **SINGLE+1** or **FAMILY** COVERAGE PLAN: **MEDICAL/DENTAL/VISION/RX**

OTHER MEDICAL COVERAGE

MEDICARE YES or NO WHO?______________________________ A / B / D ______

MEDICAID or DISABILITY BENEFITS YES or NO WHO?______________________________

VA BENEFITS YES or NO WHO?______________________________

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 INITIALS: __________ DATE RECEIVED: ______________________

Patient Referral Education Provided: YES/NO

PRC Brochure/HIPAA: YES/NO

PRC Eligibility: YES/NO Tribal ID: YES/NO POR: YES/NO