

Oneida Comprehensive Health Division Purchased Referred Care Services

Email ohc_prc_services@oneidanation.org

Phone: 920.869.2711 Fax: 920.869.1782

Mailing Address: Oneida Health Center, Attn: PRC Dept, PO Box 365, Oneida, WI 54155

The Purchased Referred Care (PRC) program is for medical, dental, vision, behavioral health and prescription services that are not available through the Oneida Comprehensive Health Division (OCHD). PRC is not an entitlement program and a referral does not imply the care will be paid by PRC. If PRC is requested to pay, the patient must meet residency and notification requirements, medical priority, and use of alternate resources. Patients must maintain a primary health care provider at OCHD (within three years) and utilize direct care services, if possible, prior to receiving a referral to an outside provider.

Eligibility Requirements:

1. Be an enrolled member, be eligible for enrollment, or a descendant of the Oneida Nation residing within Brown or Outagamie Counties.
2. Other federally recognized tribal members and descendants residing within the Oneida Nation Reservation boundaries.
3. Other federally recognized tribal members or descendants who maintain close social and/or economic ties with the Oneida Nation residing within Brown or Outagamie counties
 - a. Married to an Oneida Nation member or descendant. Proof of marriage required.
 - b. Have custody of Oneida Nation enrolled or descendant minor children.
 - c. Work for the Oneida Nation. Proof of employment required.
4. Students who meet the above guidelines at their permanent residence prior to leaving for school can continue PRC eligibility until 180 days after completion of their studies.
5. A person who is eligible but leaves the Oneida PRC Service Delivery Area (PRCSDA), may continue to be eligible for 180 days. This would include those that live in another state part time. Written notification of when they leave and return to the Oneida Nation PRCSDA is required before any claims will be paid to providers that are outside the area.
6. Foster children: eligible children who are placed in foster care outside the Oneida Nation PRCSDA by order of a court and were eligible for PRC services at the time of the court order shall continue to be eligible for PRC services while in foster care.
7. Indian children adopted by non-Native parents: Enrolled and descendant Indian children adopted by non-Native parents must meet the general eligibility criteria to be eligible for PRC services (reside within the Oneida Nation PRCSDA).
8. Non-Native woman pregnant with an eligible Native American's baby for the duration of her pregnancy through postpartum. A written paternity acknowledgement form will need to be on file.
9. Patients who have no insurance will need to be screened by the Medical Benefits Coordinator annually (or as needed) to determine eligibility for alternate resources. Failure to follow-up with additional requests/information will result in denial of payment.

Required Documentation Annually (or whenever an update is needed):

1. Proof of Tribal affiliation; Tribal ID, descendance paperwork (will be kept on file)
2. PRC Application
3. Proof of residency (POR) showing name, physical address, and visibly dated within 60 days. See provided list on page four.
 - a. PO Boxes are not acceptable for POR.
 - b. Notice from homeless shelters will be considered as temporary POR, valid for only 60 days
4. PRC eligibility will be approved for up to one calendar year from the date of receipt of application.
 - a. Updates are needed if you move to another address, or if a new PRC eligible dependent is added to the household.

Emergency Situations:

1. For after-hours urgent or severe medical problems, go directly to the hospital and notify PRC within 72 hours. Tribal elders age 55 and over are allowed 30 days to notify PRC.
2. Unsure about a medical situation? Call OCHC to seek medical advice by calling 920-869-2711, which is available after hours by an answering service. An on-call provider will be contacted to call you.
3. After hours prescriptions: Oneida's preferred provider is Walgreens located at 116 North Military Ave, Green Bay, WI 54303. Oneida members will need to present their insurance information (if applicable) and Tribal ID. If it is not possible to utilize this pharmacy or if Tribal ID is not presented/available, keep original paperwork and receipts to request reimbursement from the pharmacy that was utilized. Submit reimbursement requests to PRC Supervisor.
Please note: Patients need to utilize the Oneida Pharmacy if it is open, or you may not be eligible for reimbursement. Utilizing an outside pharmacy is for emergency or pre-approved situations.
4. When seeking emergency care outside of Brown or Outagamie county, follow the same guidelines above. Be sure to obtain information regarding the facility you went to.

Priorities of Care:

1. Priorities of care and treatment for health care services will be based on relative medical need. Medical procedures which are not funded by Federal medical care payment systems (such as Medicare) may not be within PRC's medical priorities.
2. Medical priority levels:
 - a. I. Emergent or Acutely Urgent Care Services
 - b. II. Preventive Care Services
 - c. III. Primary and Secondary Care Services
 - d. IV. Chronic Tertiary Care Services
 - e. V. Excluded Services
3. Refer to PRC to see which medical priorities are being covered at the time of your referral.

Patient Responsibilities:

1. Submit a completed PRC application and proof of residency annually. Applications will be considered incomplete if the POR is not submitted with it.
2. Bring all bills associated with your referred and emergency visits to PRC as soon as you receive them.
3. Notify PRC within 72 hours after seeking emergency room care; Elders 55 and over have 30 days to notify PRC.
4. Request your ER report be sent to your OCHD provider.
5. Respond to your insurance carrier if they request additional information.

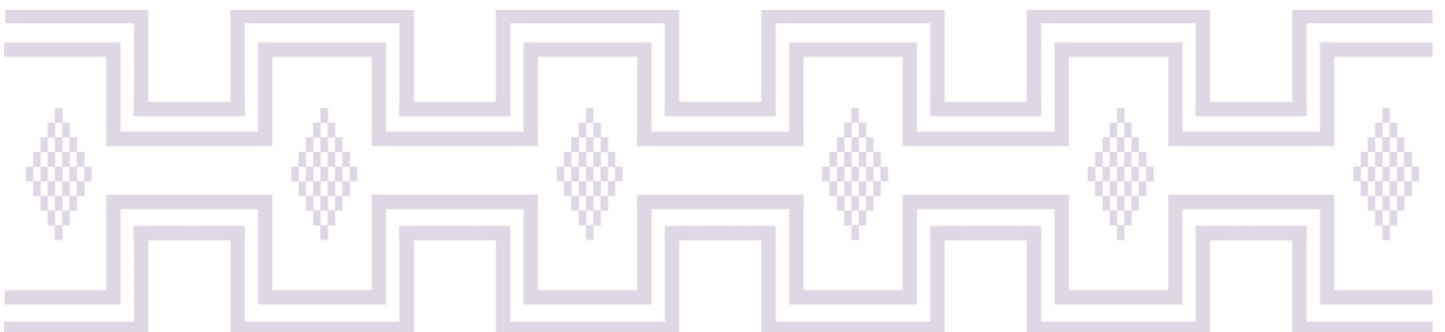
6. Take note of the number of approved visits and authorized date range on your referral form. If more visits are needed or an extension of the date range is needed, contact your OCHD provider.
7. Apply for alternate payer resources as requested and respond to all requests for additional information (i.e. provide 30 days income).
8. Contact OCHD Patient Registration and PRC if you have changed your contact information, change of insurance, removal/addition of dependents.

Appeal Process:

1. Patient's whose claims/referrals are denied for PRC services may request reconsideration and/or appeal the denial for services/payment.
2. An appeal of a denial must be submitted in writing within 30 days of the date of the denial to the PRC supervisor (or designee) at Oneida Community Health Center, PO Box 365, Attn: PRC Supervisor, Oneida, WI, 54155.
3. Appeal must indicate what they are appealing to include the date of service, provider, case number, and why the denial should be overturned; if applicable, include supporting documentation such as the denial letter.
4. PRC supervisor or designee has 10 business days from the date the appeal is received to issue a decision.
 - a. If denial is overturned, PRC will approve and process the denied claim/referral.
 - b. If denial is upheld, the patient will be notified in writing.
5. Patients may appeal the PRC supervisor decision in writing to the Utilization Review Committee (URC) within 30 days of the date of the PRC Supervisor's decision to Oneida Community Health Center, PO Box 365, Attn: Director of Nursing, Oneida, WI, 54155. URC will meet and review all documentation related to the case and decide to uphold or overturn the PRC supervisor's decision within 10 business days of receiving the written appeal.
 - i. If denial is overturned, PRC will approve and process the denied claim/referral.
 - ii. If denial is upheld, the patient will be notified in writing. There is no further appeal of the matter as URC decisions are final.

***Please keep the preceding pages for your reference. ***

07/08/21 KJD



Acceptable Documentation for Proof of Residency

All documentation must include name, street address, and dated within 60 days

- Official Government Documentation (Any State or Federal Agency)
Example: Social Security Administration, United States Postal Department, Court or Municipalities
- State/Oneida Dept of Motor Vehicle--mailed documentation
Example: Vehicle Registration Renewal Notices
- Direct Deposit receipts or payroll stubs
- Utility Bills - Heat, Water, Sewer and Garbage Disposal
- Cable, satellite, telephone, or cell phone bills
- Child Support Agencies
Example: Checks, Letters or Statements
- Acceptance letters/grants (high school/college) and dated transcripts
- Current active bank statements and e-statements with dates included
- Rental receipts or documentation from mortgage holder or landlord on company letterhead
Example: Oneida Housing Authority, Oneida Department of Land Management
 - ❖ Only valid for the duration of the lease/contract not to exceed one (1) year.
- Homeowner/Rental Insurance Statements
- Service contracts or maintenance bills for home repair/appliance delivery
Example: Furnace repair, Washer delivery, etc
- Oneida Nation mailed documentation
 - ❖ Example: Accounting Department, Child Care Department, etc

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- ❖ **Examples of UNACCEPTABLE forms of residency: personal mail, driver's license, tribal ID cards, medical bills or health/dental insurance statements, personal checks, bulk mail, envelopes, credit card statements, hand written receipts, collection statements, and correspondence from Oneida Comprehensive Health, Oneida Behavior Health.**
 - ❖ **Notices from homeless shelters will be considered as temporary Proof of Residencies, valid for 60 days only.**

Oneida Comprehensive Health Division Purchased Referred Care Application

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

APPLICANT (OCHD patient or responsible party for OCHD patient, 19 years and older)

Name		Medical Record # <i>If known or applicable</i>	
Address		County	
City, State, Zip		Phone #	
Birthdate	Tribe		Roll # (or indicate descendant)
Email Address		Employer	

SPOUSE'S INFORMATION (must be legally married)

Name		Medical Record # <i>If known or applicable</i>	
Birthdate		Phone #	
Tribe		Roll # (or indicate descendant)	
Email Address		Employer	

OTHER PRC ELIGIBLE HOUSEHOLD MEMBERS OR DEPENDENTS (Under 19 years of age)

****Household members that are patients at Oneida Comprehensive Health that applicant is responsible for****

Full Name	DOB	Relationship to Applicant	Medical Record # <i>If known or applicable</i>

PRIVATE INSURANCE INFORMATION

Leaving insurance information blank will prompt a screening from an MBC, delaying your services

Policy Holder Name		Relationship to Applicant	
Medical Insurance Carrier		Dental Insurance Carrier	
Medical Policy #		Dental Policy #	
Medical Group #		Dental Group #	
Who's covered on this policy, list names:		Who's covered on this policy, list names:	

SECONDARY PRIVATE INSURANCE INFORMATION

Policy Holder Name		Relationship to Applicant	
Medical Insurance Carrier		Dental Insurance Carrier	
Medical Policy #		Dental Policy #	
Medical Group #		Dental Group #	
Who's covered on this policy, list names:		Who's covered on this policy, list names:	

OTHER MEDICAL COVERAGE

Medicare	Y / N	Name(s)	
Medicare Type	A B C D	Medicare ID #	
Medicaid	Y / N	Name(s)	
Disability	Y / N	Name(s)	
Veteran Health Benefits	Y / N	Name(s)	

PLEASE READ CAREFULLY: Patient acknowledgement regarding residency requirements, patient responsibilities, and authorization for outside agencies: 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. I hereby authorize the Purchased Referred Care Specialist to contact other agencies to obtain information that is necessary to further enhance my eligibility, process referrals and claims. I also acknowledge that I have read the patient requirements and responsibilities and agree to abide by them. I understand that false and misleading information in my application will result in denial of benefits.

SIGNATURE OF APPLICANT _____ **DATE** _____

(or legal designee)

To be completed by PRC staff only

PRC Initials		Date Received	
Patient Ref Edu Provided	YES / NO	Tribal ID	YES / NO
POR	YES / NO	Ins Verified	YES / NO
Ins Screen Needed	YES / NO	PRC eligible	YES / NO
Additional notes:			