SOKAOGON CHIPPEWA PURCHASED REFERRED CARE AND MEDICARE RELIEF BLOCK GRANT APPLICATIONS

FOR OFFICE USE ONLY		
DATE OF APPROVAL		
MA	DENIAL ☐	ACCEPTANCE ☐
PRC	DENIAL ☐	ACCEPTANCE ☐
MRBG	DENIAL ☐	ACCEPTANCE ☐
OTHER COVERAGE	YES ☐	NO ☐
APPLICANT(S) DENIED, SPECIFY REASON:		

SECTION A - APPLICANT

LAST NAME (Head)	FIRST NAME	MIDDLE NAME (Complete)			MAIDEN NAME
ADDRESS	CITY	STATE	ZIP CODE	COUNTY	MAILING ADDRESS
HR#	BIRTH DATE	SOCIAL SECURITY NUMBER		MALE ☐	FEMALE ☐

ENROLLED SOKAOGON? YES ☐ NO ☐

ARE YOU A VETERAN? YES ☐ NO ☐

IS YOUR EMERGENCY CONTACT PERSON YOUR SPOUSE WHO WILL BE LISTED BELOW?
IF YES, CONTINUE TO SECTION B   IF NO, CONTINUE TO NEXT LINE

EMERGENCY CONTACT - NAME	RELATIONSHIP		PHONE
ADDRESS	CITY	STATE	ZIP CODE

SECTION B – APPLICANTS SPOUSE

LAST NAME (Spouse)	FIRST NAME	MIDDLE NAME (Complete)			MAIDEN NAME
ADDRESS	CITY	STATE	ZIP CODE	COUNTY	MAILING ADDRESS
HR#	BIRTH DATE	SOCIAL SECURITY NUMBER		MALE ☐	FEMALE ☐

ENROLLED SOKAOGON? YES ☐ NO ☐

ARE YOU A VETERAN? YES ☐ NO ☐

IS YOUR EMERGENCY CONTACT PERSON YOUR SPOUSE LISTED ABOVE?
IF YES, CONTINUE TO SECTION C   IF NO, CONTINUE TO NEXT LINE

EMERGENCY CONTACT - NAME	RELATIONSHIP		PHONE
ADDRESS	CITY	STATE	ZIP CODE

SECTION C – APPLICANT'S CHILDREN UNDER 18 (Living at the above address)

LAST NAME (Complete)	FIRST NAME	MIDDLE	SEX	BIRTH DATE	SOCIAL SECURITY #	✓ IF ENROLLED	HR#'S

SECTION D – OTHER MEDICAL COVERAGE

INSURANCE OR MEDICAL COVERAGE?	YES ☐ NO ☐	EMPLOYER NAME			PLEASE ATTACH COPIES OF ALL INSURANCE/OTHER COVERAGE CARD(S) (FRONT AND BACK)
INSURANCE NAME		POLICY/GROUP#			
INSURANCE NAME		POLICY/GROUP#			
PRESCRIPTION COVERAGE?	YES ☐ NO ☐	DENTAL COVERAGE?	YES ☐	NO ☐	
MEDICAL ASSISTANCE (WI)?	YES ☐ NO ☐	MEDICARE (SOCIAL SECURITY)?	YES ☐	NO ☐	

SECTION E - SIGNATURE

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT AND UNDERSTAND THAT IT IS MY RESPONSIBILITY AND OBLIGATION TO NOTIFY THE SOKAOGON CHIPPEWA HEALTH CLINIC PURCHASED REFERRED CARE PROGRAM 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

Sokaogon Chippewa Health Clinic
3144 Van Zile Road
Crandon, WI 54520
Phone: (715) 478-5180 * Fax: (715) 478-5904
www.sokaogonchippewa.com

SOKAOGON CHIPPEWA
MEDICAL INFORMATION RELEASE FORM

I hereby give the Sokaogon Chippewa Health Clinic Purchased Referred Care Program authorization to request medical records regarding myself and/or family members from our health care provider. This will streamline claims processing. All information received will be confidential under the provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This release is valid for one year from the date signed below.

HOUSEHOLD TRIBAL MEMBERS OVER 18 MUST SIGN BELOW

SIGNATURE: ______________________________ DATE: ______________________

SIGNATURE: ______________________________ DATE: ______________________

BY CHECKING AND PROVIDING THE INFORMATION BELOW, I GIVE PERMISSION TO CONTACT ME VIA:

☐ MAIL

☐ CELL PHONE: ____________________

☐ E-MAIL: ____________________

PLEASE ATTACH COPIES OF ALL INSURANCE/OTHER COVERAGE CARD(S) (FRONT AND BACK)

Ga-na-waji Ga-wi-nug Way-ji-mooki-ji-wung Yi-ewe-meing-gun-a-sepii