



YAVAPAI-APACHE HEALTH CENTER

PHONE: (928) 567-8470

FAX: (928) 567-8478

DEAR YAVAPAI-APACHE TRIBAL MEMBER:

Please fill out the application for assistance completely, front and top half back of the form, so that there will not be a delay in approving your request. Please Sign and Date the Application, if there is no signature then your request will be delayed.

The Tribal Medical Assistance Program does not pay for contacts or eye exams, only prescription eyeglasses.

Please find enclose the Release of Information that needs to be filled out and returned to my office. The reason for this is because the medical assistance is for tribal members only; by this form it will define dual enrollment or persons not enrolled with the Yavapai-Apache Nation and this will help better serve the Tribal Member.

If you have any questions regarding the above information please contact me at (928) 567-8470.

Best regards,

Vida Smith, Coordinator

Tribal Medical Assistance Program

Enclosures:

Cc: File



YAVAPAI-APACHE HEALTH CENTER

TRIBAL MEDICAL ASSISTANCE PROGRAM

PH: 928-567-8470

FAX: 928-567-8478

MAILING: 2400 W DATSI ST / CAMP VERDE, AZ 86322 / PHYSICAL: 2121 W RESERVATION LOOP RD

CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I, _____ SSN#: _____
(Print Name)

ADDRESS: _____ DOB: _____

AUTHORIZE THE DISCLOSURE OF INFORMATION FROM MY HEALTH RECORD.

The information is to be disclosed by:

Yavapai-Apache Nation Enrollment
NAME OF FACILITY
2400 West Datsi Street
ADDRESS
Camp Verde AZ 86322
CITY/STATE/ZIP CODE

And is to be provided to:

Vida Smith-Tribal Medical Assistance Program
NAME OF PERSON/ORGANIZATION/FACILITY
2400 West Datsi Street
ADDRESS
Camp Verde AZ 86322
CITY/STATE/ZIP CODE

The purpose or need for this disclosure is:

- a. Insurance
- b. Billing purposes
- c. Other (specify) C I B

SIGNATURE OF PATIENT

DATE

SIGNATURE OF PERSONAL REPRESENTATIVE (State relationship to patient)

DATE

Yavapai-Apache Nation
2400 WEST DATSI
CAMP VERDE AZ 86322
(928)567-8470

DENTAL * MEDICAL * VISION ASSISTANCE APPLICATION

Applicant Name: _____ Enrollment# _____

Cell# _____

Date of Birth: _____ Social Security# _____ Ph# _____

Mailing Address: _____

Physical Address: _____

<i>I AM APPLYING FOR THE FOLLOWING ASSISTANCE</i>	
<input type="checkbox"/>	EYEGASSES
<input type="checkbox"/>	BRACES (UNDER 18 YEARS OF AGE)
<input type="checkbox"/>	EMERGENCY DENTAL
<input type="checkbox"/>	MEDICAL PRESCRIPTION
<input type="checkbox"/>	MEDICAL BILLS
<input type="checkbox"/>	

BRIEFLY DESCRIBE YOUR PRESENT SITUATION; WHY ARE YOU REQUESTING THIS ASSISTANCE:

Dental, Medical & Vision Assistance

Every Time A Tribal Member Is Requesting Assistance An Application Must Be Fully Completed.

By Signing This Application, I Am Stating That The Information Provided To This Office Is True To The Best Of My Knowledge. I Understand That I Do Have A Right To Request A Review Of My Application If A Decision Is Made That I Do Not Agree With.

Applicant Signature:

Date:

Interviewer's Signature:

Date:

PLEASE COMPLETE (1) THRU (4) BY CHECKING THE (YES) OR (NO) BOX. IF THE BOX IS NOT CHECKED THEN YOUR APPLICATION FOR ASSISTANCE WILL BE DELAYED UNTIL ALL INFORMATION IS COMPLETE.

(1) IS CLIENT ENROLLED WITH AHCCCS? () YES () NO
OR MEDI-CAL STATE HEALTH INSURANCE? () YES () NO
AHCCCS PLAN NAME _____
AHCCCS ID# _____

(2) IS CLIENT COVERED BY MEDICARE: () YES () NO
A _____
B _____

(3) IS CLIENT COVERED BY KIDS CARE? () YES () NO

(4) IS CLIENT COVERED BY PRIVATE INSURANCE? () YES () NO

PLAN NAME _____

POLICY NUMBER: _____

PRIMARY INSURER: _____

VISION _____

DENTAL _____

Applicant is APPROVED for _____ effective _____ 2011

Applicant has been DENIED for _____ effective _____ 2011

APPLICANT IS DENIED FOR THE FOLLOWING REASON(S):

Interviewer's Signature: _____

Date: _____