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

MAIL: 2400 W. DATSI STREET • PHYSICAL: 2121 RESERVATION LOOP ROAD • CAMP VERDE, ARIZONA 86322

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#__________________

MailingAddress:____

Physical Address:____

I AM APPLYING FOR THE FOLLOWING ASSISTANCE	
	EYEGLASSES
	BRACES (UNDER 18 YEARS OF AGE)
	EMERGENCY DENTAL
	MEDICAL PRESCRIPTION
	MEDICAL BILLS

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 IsTrueTo 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:**

REVISED 5/14/10