



# CHICKASAW NATION MEDICAL ASSISTANCE PLAN APPLICATION

\*For eligibility guidelines and program procedures, please see attachment.

PLEASE PRINT

Patient Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Current Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ Gender:  M  F Date of birth: \_\_\_\_\_  
Home Phone Work Phone

Chart # (must have an active chart to be eligible)\* Chickasaw citizen?  Yes  No  
Please check the facility you utilize:  Ada  Ardmore  Durant  Purcell  Tishomingo  
Have you applied for medical assistance through this program before?  Yes  No (If yes, please provide dates:)

**If patient cannot fill out form please list your name below:**

Relationship to patient: \_\_\_\_\_  
Last First MI

Mailing Address (if different) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Home Phone

Check all available resources:  Private Insurance  Medicare  Medicaid  Other (please list)

\*Please provide a copy of card\*

**NOTE: Please complete part 1 or 2, not both.**

1.  REQUEST FOR PRE-APPROVAL (please fill out this box only and skip to the bottom to sign)

Type of care that patient needs: \_\_\_\_\_

If you have an appointment please list the date: \_\_\_\_\_

Have all alternate resources been exhausted?  Yes  No

Have medical claims been denied from contract health or available programs?  Yes  No

2.  REQUEST FOR FINANCIAL ASSISTANCE FOR SERVICES ALREADY RECEIVED

Date of illness/injury: \_\_\_\_\_ Nature of illness/injury: \_\_\_\_\_

Location of services provided:  Hospital  ER  Physician's office

Type of care that patient has received: (please explain) \_\_\_\_\_

Have medical claims been denied from Contract Health or available programs?  Yes  No

**If yes, please provide documentation - Denial letter.**

Have all alternate resources been exhausted?  Yes  No

Have any medical claims been paid by patient?  Yes  No

**If yes, please provide receipt from billing department showing payment and proof of payment.**

Have bills been turned over to a collection agency?  Yes  No

**PLEASE PROVIDE ORIGINAL STATEMENT/INVOICE WITH THIS APPLICATION**

**This application should be returned to:**

Chickasaw Nation Division of Health  
Chickasaw Nation Medical Center  
Attn: Tribal Health Program  
1921 Stonecipher Blvd.  
Ada, OK 74820

(All incomplete applications will be returned. A copy of the Chickasaw Nation citizenship card must be included, no exceptions.)

I hereby release any and all medical information necessary to process this application for assistance.

\_\_\_\_\_  
Patient's signature

\_\_\_\_\_  
Date