



CHICKASAW NATION DIVISION of HEALTH (CNDH) CHICKASAW ELDERLY PRESCRIPTION PROGRAM

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 # for CNDH** **Chickasaw citizen?** Yes No
(must have an active chart to be eligible)

Check all available resources: ***Note: Please provide a copy of card***

Private Insurance Medicare Medicaid Other (please list)

Patient's signature: _____ **Date:** _____

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

(Attach a copy of your Chickasaw Nation citizenship card to this application.)

(Applications not complete will be returned.)

(Controlled substance not eligible for program.)

Eligible prescriptions should be submitted with this form and returned to:
 Chickasaw Nation Division of Health
 Chickasaw Nation Medical Center
 Attn: Tribal Health Program
 1921 Stonecipher Blvd.
 Ada, OK 74820

Eligibility: (Patients must fill out application and sign.)

1. 60 years of age or older
2. Chickasaw citizen with a Chickasaw Nation citizenship card.
3. In need of a prescription medication that is not provided by Chickasaw Nation pharmacy.
4. Prescription from your CNDH primary care physician.
5. All refill orders must be ordered through the CNDH Pharmacy - Phone – (580) 421-4569