CHICKASAW NATION DIVISION of HEALTH (CNDH)
CHICKASAW MEDICATION ASSISTANCE 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. **Chickasaw citizen with a Chickasaw Nation citizenship card.**
   (Under the age of 12 – mother's or father's card(s) must accompany child's CDIB.)
2. **In need of a prescription medication that is not provided by Chickasaw Nation pharmacy.**
3. **Prescription from your CNDH primary care physician.**
4. **All refill orders must be ordered through the CNDH Pharmacy - Phone – (580) 421-4569**