The Chickasaw Nation Services at Large (SAL)
Tribal Health Program

☐ Eyeglass Program

Patient name: ____ **Gender:** ☐ **M** ☐ **F** **Marital status:** _____________
Last First MI

Date of birth: _______________ **City of birth:** __________________ **State of birth:** _______ **SSN:** _____-____-______

Current mailing address: ____

City: ______________________________ **State:** ______________ **Zip:** ___________

City of residence, unless same as mailing address: ______________________________

(_____) ______________ (_____) ______________ (_____) ______________
Home phone **Work phone** **Emergency contact number**

Email address: ____

Tribal membership: ________________________________

Tribal degree: __________ **Other tribes:** __________________________________ **Total degree:** __________

Employer's name (or status): ____

Chickasaw citizen? ☐ **Yes** ☐ **No**

Attach a copy of your Chickasaw Nation citizenship and CDIB card to this application.

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

☐ **Private insurance** ☐ **Medicare** ☐ **Medicaid** ☐ **Vision insurance**

☐ **Other (please list plan name):** ____

Policy holder's name: ______________________________________ **Policy holder's date of birth:** _______________

Effective date of coverage: _______________

Under penalty of law I hereby understand and agree to all conditions of participation and guidelines of the program.

Patient's signature: ____ **Date:** _______________
(or legal guardian)

Conditions of Participation:

1. Chickasaw citizen with a Chickasaw Nation citizenship card and CDIB.
2. Recent eye exam with glasses prescription.
3. Prescription from your primary eye care provider.
4. Frame and lenses to be supplied by Oklahoma Optical.
5. Complete ordering information enclosed for frame and lenses, to include fitting and dispensing measurements.
6. Order form on back completed by eye care provider.
7. Total tribal benefit of $125.00 to be applied to cost of frame and lenses.
8. Cost of eye exam not included.
9. Insurance benefits must be assigned to program.
10. Payment from private insurance must be turned in to program.
11. Frame overage and cost of specialty lens material to be paid by cashier's check or money order at the time of order.
12. Provider information must be submitted with application.
13. One pair of glasses provided every two years.

Complete information on back of form

Incomplete applications will cause delays. Answer all questions before submitting.

Return to: The Chickasaw Nation Division of Health
Attention: Tribal Health Program
1005 N. Country Club Rd.
Ada, OK 74820
Toll free 1-800-851-9136 Ext. 80920 or Phone: (580) 559-0792
Fax: (580) 559-0793

Provider information:

Printed name: ____

Address: ____ **City:** ______________ **State:** _____ **Zip:** ________

Phone (_____) ______________ **Fax** (_____) ______________

Business name of facility: ____

State license no.: ______________________________ **State of** ______________________

Patient name: ____ Rx #: ____________________

	SPHERE	CYLINDER	AXIS	PRISM	BASE	ADD
RIGHT						
LEFT						

	SEG HEIGHT	PD Dist	PD Near
RIGHT			
LEFT			

Material
Glass
Plastic
Hi-Index
Polycarbonate
Trivex

SV
Sv Asph sv

FLAT-TOP
FT-25 FT-28 FT-35 Executive Round

TRI-FOCAL
7x25 7x28 7x35 8x35 Executive

PROGRESSIVE
Image VIP Varilux Physio
Physio Crizal Alize' w/clear guard
Physio 360 Crizal Alize' w/clear guard
Kodak- Concise Precise

TRANSITION
Brown Grey

GLASS
Clear
Photo Brown Photo Grey

Special Instructions

☐ 3.0mm SAFETY

TINT
☐ Gradient
☐ Solid
☐ UV
☐ Clear

Special Coatings
☐ Scratch coat
☐ AR
☐ Polarized
☐ Mirrored
(Specify)_____________

EYE SIZE	ED	DBL	TEMPLE
FRAME NAME	COLOR	FRAME: Enclosed Supply To Follow Other________________________ (Specify)	

FRAME MANUFACTURER

Zyl Metal Rimless Drill | Lenses Only

Internal Use Only

Signature of Provider: ____ **Date:** ______________