



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

Pharmacy Refill Center

Patient name: _____ Gender: M F
Last First MI Marital Status: S M D W
Date of birth: _____ City of birth: _____ State of birth: _____ SSN: _____-_____-_____

Current mailing address: _____
City: _____ State: _____ Zip code: _____

City of residence, unless same as mailing address: _____

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

E-mail address: _____

Tribal citizenship: _____ Degree of blood: _____

Other tribes: _____ Total degree of blood: _____

Employer's name (or employment status): _____

Chickasaw citizen? Yes No

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

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

Private insurance Medicare Medicaid Medicare Part D (prescription drug)

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. Private insurance drug or Medicare Part D coverage active.
2. Any age with drug insurance; age 18 or under without coverage.
3. Chickasaw citizen with a Chickasaw Nation citizenship card and CDIB.
4. In need of a prescription medication that is not available from a local Indian Health Service pharmacy.
5. Original prescription from your physician (phone-ins and transferred prescriptions not accepted).
6. All refill orders must be ordered through the CNMC Pharmacy – Phone – (580) 559-0794, toll free 1-800-851-9136.
7. Insurance benefits must be assigned to pharmacy program.
8. Payment from private insurance must be turned in to program.
9. Enrollment required prior to participation.
10. Physician information must be submitted with application.
11. Prescription must be within scope of offered medications.
12. Not currently receiving services from the Chickasaw Nation Division of Health in Oklahoma.

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

**Return to: The Chickasaw Nation Division of Health
Attention: Services at Large Prescription Coordinator
933 N Country Club Road
Ada, OK 74820**

**Toll free 1-800-851-9136 or 1-888-272-9635 Ext. 81518 or (580) 559-0794
Fax: (580) 559-0609**

(Complete information on back of form)

Prescription Information: [original signed prescription(s) must be attached]

Dear Doctor: Your patient has requested medication provided through a tribal benefit of the Chickasaw Nation. In order for him/her to receive his/her prescriptions we require some information before determining if this can be provided by our program. Please complete the following. The patient will be notified if the prescription can be filled prior to it being processed. Allow sufficient time for dispensing and mailing.

Medication List:

	DRUG ALLERGIES:

Physician Information:

Printed name: _____
Address: _____ City: _____ State: _____ Zip code: _____
Phone (____) _____ Fax (____) _____
Specialty: _____
State license no.: _____ State of _____ DEA no.: _____
NPI no.: _____

On behalf of my patient, _____, I request the above medication be provided through the Chickasaw Nation Tribal Health Program. I certify that the patient is under my care at this time and will be followed appropriately. The medication prescribed for my patient is in accordance with the scope of covered drugs (*see below*) available under this program. I agree to provide additional information necessary to process claims to Medicare or private insurance on behalf of my patient. I further state that I am licensed to practice medicine in the indicated state above with evidence of active participating privileges in state and federal programs.

Signature of provider: _____ Date: _____

Non-covered drugs:

- Anti-rejection
- Chemotherapy
- Compounded substances
- Controlled substances
- Investigational
- IV Medications/devices to administer drugs
- Over-the-counter
- Performance enhancing
- Short-term use

For Internal Use Only	
ID/Voucher # _____	Acceptance notice mailed _____

Coordinator name: _____