the Chickasaw Nation

Bill Anoatubby
Governor

Department of Administration / Tribal Health Division
Services at Large - Health Spending Account / Tribal Health Programs
45 North 9th Street / Suite 307 / Duncan, OK 73533 / (580) 470-2115 / Fax: (580) 252-3926
Email address: HSA@Chickasaw.net

Application checklist:
☐ Application
☐ Insurance card
☐ Expenses
☐ Electronic Banking Vendor Accounts Authorization Form

Health Spending Account Application

Chickasaw citizen? ☐ Yes **(complete application)** ☐ No **(not eligible)**

Patient name: _____
First Middle Last Suffix

Gender: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth date: _____ Social Security no.: _____

Mailing address: _____
Street City State ZIP

Physical address: _____
Street City State ZIP

Home phone no.: (___) _____ Work phone no.: (_____) _____

Email address: _____

Permission for verbal communication:

Name: _____ Phone no.: (___) _____ Relationship: _____

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Incomplete applications will delay setting up your account and processing your reimbursement.

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Program guidelines:

- A maximum of $300 per month is reimbursed to the Chickasaw citizen.
- Reimbursement by direct deposit into banking account **(must complete Electronic Banking Vendor Accounts Authorization Form)**.
- **Expenses must be submitted within 30 days of payment.**

Eligibility requirements:

- Chickasaw citizen with a Chickasaw citizenship card.
- Aged 65 or older or permanently disabled and on Medicare.
- Reside **outside** the Chickasaw Nation treaty territory.
- Not currently receiving services from the Chickasaw Nation Department of Health.

Reimbursable services:

Please check below the medical expense(s) you anticipate using for your Health Spending Account benefit. **You may check more than one.**

☐ Monthly premiums for Medicare Part B (outpatient care) and/or Medicare Part D (prescription drug coverage).
☐ Vision care premiums and deductibles.
☐ Dental care (i.e., prevention and treatment).
☐ Prescription expenses - over-the-counter medications are excluded.
☐ Insurance deductibles and co-pays.
☐ Supplemental insurance premiums.
☐ Qualified medical expenses.

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Under penalty of law, I attest that all statements are true and I hereby understand and agree to eligibility requirements, reimbursable services and program guidelines. I hereby release any medical information necessary to process this application for assistance.

_____ _____
Patient/legal guardian signature Date

Mail completed application to:
The Chickasaw Nation Tribal Health Program
45 North 9th Street, Suite 307
Duncan, OK 73533
For information: (580) 470-2115, Ext. 61301
Fax: (580) 252-3926
Email address: HSA@Chickasaw.net