GTB Purchased/Referred Care Update

Grand Traverse Band of Ottawa and Chippewa Indians
2605 N. West Bay Shore Drive
Peshawbestown, MI 49682
(231) 534-7884 or (231) 534-7210

Section 1 PRIMARY TRIBAL MEMBER INFORMATION

Last Name X______________________ First NameX ______________________MiddleX__________

Social Security NumberX ________________ Date of Birth X____________ Tribal Enrollment #X ________________

Physical Address:X ______________________ Mailing Address: X______________________

City: X____________ State:X _____ ZipX________ Phone Number:_X______________ Sex:X Male _____ Female _____

XMarital Status: Single ____ Married ___ Divorced ___ Widowed ___ Date of Marriage: __________ Date of Divorce: ___________

Section 2 Tribal Member's Family Information

Name of Tribal Members	Relationship	Date of Birth	Tribe/Enroll # (if applicable)	Sex	Social Security #	Address (if different from above)	Current Insurance
X							

PRC Member ID:________________ **Effective Date:** __________ **FY**______ **HRN#**___________

UPDATED 04/07/14

Section 3 Insurance Information

Name of Tribal Members	Current Insurance Coverage	Insurance Numbers	Effective Dates	Medical	Dental	Vision	Prescription Drugs
X	X	X	X	X	X	X	X

I certify that all statements are true and complete to the best of my knowledge. I authorize any physician, medical facility, employer, having information as to employment, medical coverage, or medical care, for my spouse, dependent children and myself to give such information to GTB Purchased Referred Care or its administrators to determine Eligibility for coverage. GTB Purchased Referred Care is a payer of last resort. I agree that the company may release such information to its representatives or re-insurers or as permitted by law. I also understand that if I or any members listed on this application use the GTB Family Health Clinic we may also be eligible for services under the Medical Relief Block Grant.

***Signature of Tribal Member __X________________________________ DateX ____________________

AUTHORIZATION TO DISCUSS MEDICAL SERVICES WITH DESIGNATED PERSONS

I, (APPLICANT) X____HEREBY AUTHORIZE THE RELEASE OF INFORMATION REGARDING MY HEALTHCARE AND BILLING TO THE **GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS PURCHASED/REFERRED CARE**.

GTB PRC Staff: Stella Chippewa, ____________, Monica Anderson, Angelina Raphael__ ____________
NAME(S)

2605 N. West Bay Shore Dr. Peshawbestown, MI 49682
ADDRESS (IF DIFFERENT)

231-534-7884
PHONE NUMBER

MY SIGNATURE PROVES THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND EXPLAINED TO ME IN A LANGUAGE THAT I UNDERSTAND. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL EXPIRE 1 (ONE) YEAR FROM THE DATE SIGNED OR IMMEDIATELY UPON RECEIPT OF WRITTEN REQUEST TO REVOKE.

APPLICANT'S SIGNATURE:X____DATE:X__________________________

VERIFICATION OF RECEIPT OF PURCHASED REFERRED CARE INFORMATION

X______ I HAVE RECEIVED THE PURCHASED/REFERRED CARE (PRC) INFORMATION. I WILL REVIEW IT AND
INITIALS IF I HAVE ANY QUESTIONS I WILL CONTACT THE PURCHASED/REFERRED CARE ELIGIBILTY SPECIALIST.

VERIFICATION OF YEARLY UPDATE & CHANGE IN CONTACT INFORMATION

X______ I UNDERSTAND THAT MY PRC FILE **MUST** BE UPDATED ONCE A YEAR DURING THE MONTH OCTOBER. I ALSO UNDERSTAND THAT FAILURE
INITIALS TO UPDATE AND REPORT ANY CHANGES IN MY ADDRESS, NAME, PHONE NUMBER / CONTACT INFORMATION, OR MEDICAL COVERAGE(S) COULD RESULT IN SUSPENSION OF MY BENEFITS THROUGH GTB PURCHASE/REFERRED CARE.

WITH MY INITIALS ABOVE AND MY SIGNATURE BELOW I AGREE THAT I HAVE RECEIVED THE PURCHASED/REFERRED CARE INFORMATION. I ALSO KNOW THAT I **MUST** UPDATE MY FILE ONCE EVERY YEAR DURING THE MONTH OF OCTOBER.

APPLICANT'S SIGNATURE:X____DATE:X__________________________

PURCHASED/REFERRED CARE (PRC)
AUTHORIZATION INFORMATION

You must obtain authorization from PRC at least **2 days/48 hours before your scheduled appointment**. Any appointments called into PRC the day of will result in you either rescheduling or be responsible for any charge incurred on that day.

X-rays and Lab Work will be same day approval.

Authorization for Emergency Room/Urgent Care Visit:
*Notify PRC within 3 days/72 hours of onset of illness/accident.
*Elders & persons with disabilities have up to 30 days to notify PRC of illness/accident.
*When needing to go to Urgent care you are to use the MCHC Urgent Care at 550 Munson Ave in Traverse City. Only use the Main Munson Medical Center for Emergency life threatening situations.
.
PURCHASED/REFERRED CARE APPOINTMENT HOTLINE—231-534-7223
Use this number to call in any appointments you have or will have. Appointments must be called in 48 hours in advance. The hotline is checked daily for the processing of authorizations for eligible PRC clients.

Authorization for Prescriptions:
Must use the following Pharmacies:
Bayshore Pharmacy 231-271-6111
MCHC Pharmacy 231.935.8730

- **New PRC Clients –** will be able to get prescription the next business day after signing up for PRC unless you need to get prescription the same day. **EMERGENCY ONLY**!

PRC Priority Levels of Care
PRC payment is limited by priorities. Priority Levels of Care are posted at the clinic, PRC office and GTB Government buildings. Therefore, some treatments and procedures may be deferred based on levels of funding. PRC is not an entitlement program and cannot guarantee payment.

For any PRC questions you may have, please do not hesitate to call one of us below:

Stella Chippewa, PRC Manager/PD 231-534-7931
, PRC Customer Service 231-534-7884
Monica Anderson, PRC Eligibility Specialist 231-534-7210
Angelina Raphael, Benefits/PRC Intake Coordinator 231-534-7731

Client Print Name:____ Client Signature:______________________________ Date:______________

PRC Staff Signature:_________________________________ Date:____________________

Cc:file