

***HEALTH & SOCIAL
SERVICES
BENEFITS
MANUAL***

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GENERAL INFORMATION—The Eastern Shawnee Tribe of Oklahoma’s Health & Social Service Program is funded by tribal business ventures. The program offers assistance for school expenses, healthcare, burial, utilities and elder/disabled care needs for all tribal members. The program operates on a tribal budget that has a maximum for payment on each service that has been set by the Business Committee. The program follows a 1st come 1st serve basis. The program operates on the fiscal year (October 1—September 30.) The guidelines and requirements for this program are as follows:

- ◆ *All claims must be submitted within 90 days from the date of service or insurance payment and must be submitted or postmarked on September 30th to be processed for that fiscal year. Any claims submitted after 90 days will be returned to you and will be your responsibility. All claims shall be subject to the availability of funds.*
- ◆ *Only enrolled members of the Eastern Shawnee Tribe of Oklahoma are eligible to apply and receive services from this program. Future tribal members will be eligible for services after date of enrollment and all dates of service must be on or after enrollment date. Services are for every member regardless of income, age or residence, unless stated otherwise. Payments will be made to the parent who has been adjudicated custody of the child/children by a court of law.*
- ◆ *All tribal members must have an **Authorization to Release Information** form on file. In order to release certain information to family members, an **Authority to Release Information to a Designated Individual** form must be on file.*
- ◆ *Payments will be made to vendors when at all possible. **This does not include utilities, unless stated otherwise.** However, applicants paying for services at time of service can be reimbursed upon receipt of a paid invoice. If you have healthcare insurance complete the **Coordination of Benefits Questionnaire** and file all claims with your insurance company first. We will reimburse only your out-of-pocket expenses.*
- ◆ *For reimbursement of expenses, complete a **Reimbursement Request** form and attach ORIGINAL documentation along with proof of payment. Documentation must show the business name with date of service or purchase. DO NOT highlight or write on any receipts as they could be considered altered and will not be processed. For direct payment to vendors, complete a **Direct to Vendor Payment Health Expense Claim** form and attach ORIGINAL billing statement. Make copies of all your paperwork for your records as originals will not be returned. There is a \$25 minimum check amount.*
- ◆ ***Please allow a minimum of 30 days for your claim to be processed for a reimbursement check to be issued.** The Health & Social Service Department and the Accounting Office both encounter tremendous work load requirements. Calling staff inquiring as to the status of a claim only creates a setback for the Departments in completing your claims in the time allotted.*
- ◆ *There is a \$30 fee for each stop payment request that is processed. If a stop payment of check is required, the tribal member agrees to hold the Eastern Shawnee Tribe harmless for the stop payment fee. The Eastern Shawnee Tribe will not be responsible for any fees due to inadvertence on the tribal members part.*
- ◆ *Any person willfully attempting to defraud the Eastern Shawnee Tribe will not be considered for any services of this program. The Business Committee reserves the right to revoke, suspend, or terminate the eligibility of any tribal member for a period of time to be determined and set forth by the Committee.*

PRE-AUTHORIZATION OF TREATMENT

It is highly recommended that a provider obtain prior authorization for treatment in order for the claim to pay according to your benefits. A pre-authorization is a request made prior to a procedure to verify benefits. This allows the patient to make an informed decision of potential coverage for the procedure in advance. The pre-authorization assists not only the provider to expedite their workflow but is a benefit for you as well. You will have advance notice of the extent of the work involved—health wise and financially.

SUBMITTING YOUR CLAIM

For reimbursement or direct payment of expenses, complete either the **Reimbursement Request** or the **Direct to Vendor Payment** form along with your ORIGINAL paperwork. Members should collect their claims & send them in once a month. Do not highlight or write on the receipts, as they could be considered altered and will not be processed. Receipts must show the business name with date of purchase. Direct payment to a vendor must show the name of the tribal member, address and telephone number of the facility, type of service received, date of service and all charges. The entire original bill for payment to vendor is required. Submitting just the bottom or top portion of a bill will not be accepted.

You must file your claims with any **Primary** provider first. The program will only pay or reimburse for out-of-pocket expenses incurred from the unmet expenses not paid by the primary provider. Funds can be used only after all other resources have been exhausted. Failure to comply with alternate resource policies may result in the denial of future services. Any duplicate payments made by the Health & Social Service Program and a Primary Provider must be returned to the Eastern Shawnee Tribe of Oklahoma. Failure to reimburse the tribe may result in denial of future services.

Some benefits require more than just a receipt or a direct to vendor payment. The following are additional documentation that must be enclosed with your request:

- School supply expenses must be accompanied by the school supply list provided at the beginning of each school year. Other school supplies required throughout the school year must be accompanied by a statement from the teacher that child needs that particular item for their school curriculum. Expenses must be on a separate receipt from your regular purchases.
- Healthcare expenses must be accompanied by your insurance Explanation of Benefits (EOB) and proof of payment to healthcare facility.
- You must supply an explanation from the doctor as to the medical necessity for special medical equipment/supplies or orthodontics. Keep in mind that over-the-counter and homeopathic medicines do not apply.
- The customer/duplicate prescription receipt or pharmacy printout must be provided. No cash register receipts.
- Burial expenses must be accompanied by a copy of the death certificate and/or the **original** state certified birth certificate that proves the paternal/maternal relationship for a non-enrolled child.

FORMS

Enclosed you will find the following forms to process your claims...

- *Reimbursement Request
- *Direct to Vendor Payment
- *Benefits Questionnaire
- *Pre-Authorization of Treatment
- *Filing a Reimbursement Claim
- *Authorization to Release Information
- *Authorization to Designate Individual
- *Landlord/Roommate Utility Form

FRAUDULENT SANCTIONS POLICY

The Eastern Shawnee Tribe of Oklahoma is a federally recognized Indian tribe; therefore theft of funds from the tribe is a criminal offense, which is punishable by law. This policy was created in order to protect the trust tribal members have placed in the staff of the Eastern Shawnee tribal office and conduct the Health & Social Service programs with integrity. This will insure that funds continue to be available to all the tribal members who have needs and qualify for Health & Social Service benefits. The following actions will occur with any fraudulent claims submitted...

- ATTEMPTED FRAUD - Warning with denial of claim package that contained fraudulent material. Multiple attempts shall result in the review of suspension of services.
- PROVEN FRAUD - One (1) year household suspension from ALL tribal programs, with suspension permanent until repayment of all monies are reimbursed to the tribe.
- REPEATED FRAUD - Suspension to be determined by the Social Service Review Board. Suspension could range as far as lifetime banishment from ALL tribal programs.

*****Any unusual or questionable claims will be reviewed by the Social Service Review Board for validity*****

TITLE 18>PART 1>CHAPTER 53>§ 1163

EMBEZZLEMENT AND THEFT FROM INDIAN TRIBAL ORGANIZATIONS

Whoever embezzles, steals, knowingly converts to his use or the use of another, willfully misapplies, or willfully permits to be misapplied, any of the moneys, funds, credits, goods, assets, or other property belonging to any Indian organization or entrusted to the custody or care of any officer, employee, or agent of an Indian tribal organization; or Whoever, knowing any such moneys, funds, credits, goods, assets, or other property to have been so embezzled, stolen, converted, misapplied or permitted to be misapplied, receives, conceals, or retains the same with intent to convert it to his use or the use of another—Shall be fined under this title, or imprisoned not more than five years, or both; if the value of such property does not exceed the sum of \$1,000, he shall be fined under this title, or imprisoned not more than one year, or both. As used in this section, the term “Indian tribal organization” means any tribe, band, or community of Indians which is subject to the laws of the United States relating to Indian affairs or any corporation, association, or group which is organized under any of such laws.

DENIAL APPEAL

If your claim is denied, you may appeal the decision in accordance with the following procedure...

- Step 1 -- A written appeal to the **Program Director** for reconsideration. You will have ten (10) working days from the date of the written denial to appeal the decision.
- Step 2 -- If the matter is not resolved to your satisfaction in Step One of the appeal, you may submit a written appeal to the **Social Service Review Board**. The Board will review your request and notify you of their decision within ten (10) working days from the date of your appeal.
- Step 3 -- If the applicant is not satisfied with the decision of the Review Board, a written request stating the condition of the appeal may be submitted to the Eastern Shawnee **Business Committee** for consideration at a regular scheduled Business Committee meeting. The applicant may be requested to appear at the meeting.

BENEFITS

SCHOOL EXPENSE benefits are available each fiscal year for eligible tribal member children. Preschoolers through the 12th grade, plus homeschooled tribal children are eligible for up to \$750 assistance. For child to be eligible for school expenses they must meet the following requirements...

- ⇒ Child must be an enrolled Eastern Shawnee member
- ⇒ Applicants applying for membership will be eligible for school expense benefits on or after date of enrollment. All school expense receipts must be dated on or after enrollment date
- ⇒ Child must be attending school regularly, kindergarten through 12th grade. Preschoolers (3 & 4 year olds), must attend a regular certified 5-day school schedule

Proof of school enrollment must be provided every school year. This can be in the form of a statement from a school official on school letterhead, a class schedule, pre-enrollment records or report cards. Parents that are homeschooling can provide a written, signed statement indicating that the child is receiving instruction by other means with each child's educational plan (curriculum) or learning schedule.

The full amount of benefits allocated for each child must be spent on that particular child only. Payment will be made to the persons that have been awarded primary custody/guardianship of the child/children by a court of law for all custodial cases. Custodial parents or legal guardians must provide legal documentation stating placement of children. The Eastern Shawnee Indian Child Welfare Department will be responsible in cases of exclusive jurisdiction.

Reimbursements are for school related expenses related to attendance and academics.

Allowable expenses include, but are not limited to:

School Clothing >> Drivers Education >> Lab Fees >> Letter Jacket (no patches) >> Science Projects >> Summer Academics >> Traditional School Supplies >> Testing Fees

Non-allowable expenses include, but are not limited to:

Animals/Supplies >> Band/Chorus >> Cafeteria Charges >> Class Rings >> Class Trips >> Computers/Software >> Dance >> Daycare >> Extracurricular Activities >>Gloves/Mittens >> Hats/Sock Caps >> Jewelry >> Junior/Senior Benefits >> Music/Movies >> Music Lessons >>Pajamas >> Personal Hygiene Items >> Purses/Wallets >> Senior Pictures >> Swimwear >> Transportation Fees >> Yearbooks

HEALTHCARE benefits are available up to \$1500 each fiscal year; **Auditory** benefits are available up to \$500 each fiscal year; **Special Medical Equipment** benefits are available up to \$300 each fiscal year; and **Orthodontic** benefits are available with a **LIFETIME COVERAGE** benefit of \$750.

These benefits are available for all eligible tribal members who meet the following criteria...

- ⇒ Must be an enrolled Eastern Shawnee member
- ⇒ Applicants applying for membership will be eligible for all healthcare benefits on or after date of enrollment. All healthcare expense receipts must be dated on or after enrollment date

All healthcare benefits are available for your out-of-pocket expenses after all other resources have been exhausted. Other programs or alternate resources are considered as **Primary Providers**. Other resources can consist of...

- | | |
|------------------------|------------------------------------|
| *Health Insurance | *Medicare/Medicaid |
| *Dental Insurance | *Vision Insurance |
| *Workers' Compensation | *Federal/State Programs |
| *Auto Insurance | *Veteran's Administration Benefits |

The **healthcare** benefit is for the prevention, treatment and management of illness and the preservation of mental and physical well-being through the services offered by medical and health professionals. The customer/duplicate prescription receipt or pharmacy printout must be provided.

Allowable expenses include, but are not limited to:

Ambulance Service >> Chiropractic Services >> Dental >> Eye Exams >> 1 pair of eyeglasses a year with exam OR a year's worth of contacts with exam >> Hospice Care >> Hospital Care >> Lab Work/Testing >> Mental Disorders >> Physician Care >> Physical Therapy >> Prescriptions (filled & dispensed by a licensed pharmacist) >> Radiation/Chemotherapy >> Substance Abuse

Non-allowable expenses include, but may not be limited to:

Abortion >> Administrative Cost of Completing Claims/Form/Reports/Providing Records >> Broken/Missed Appointment Fees >> Exercise Programs >> Experimental/Not Medically Necessary >> Massage Therapy >> Over the Counter Medication with or without Rx >> Personal Comfort/Hygiene Items >> Product Service/Insurance Agreements >> Sex Changes >> Travel or Accommodations

The **auditory** benefit is for auditory devices such as hearing aids. Doctor visits, tests, fittings and batteries will be included as an auditory benefits.

The **special medical equipment** benefit is to help improve the quality of life for members with special needs. You may be required to provide valid medical documentation.

Allowable expenses include, but are not limited to:

Back/Joints Brace/Supports >> Bath Bench/Shower Chair >> Bedside Commode >> Blood Pressure Units >> Canes/Crutches/Walkers >> Colostomy Supplies >> Diabetic Supplies >> Grab Bars/Safety Rails >> Hospital Bed >> Initial Wig after Chemotherapy >> Lift Chair >> Mastectomy Bra >> Nebulizer >> Oxygen Systems >> Pediatric Feeding Pumps >> Respiratory Therapy Equipment >> Scooters >> Wheelchair **** If you're on Medicare/Medicaid you may be allowed to rent-to-own equipment ****

Non-allowable expenses include, but are not limited to:

Food >> Household Furniture >> Pets

The **orthodontic care** benefit is for the placement of braces to help straighten crooked teeth, close gaps between the teeth, and fix a bad bite to improve your dental health. **Funds are not available for cosmetic purposes.**

BURIAL benefits are available up to \$5,000 for eligible tribal members, unborn child eligible for membership or child that would be eligible for membership who meets the following requirements...

- ⇒ Must be an enrolled Eastern Shawnee tribal member
- ⇒ Child must be recognized as the tribal members natural born child. An original **State Certified Birth Certificate** must be provided proving paternal/maternal relationship

The full amount of benefits allocated for each member must be spent on that particular member only. Payment will be made to the person that has been awarded primary custody/guardianship of the child/children by a court of law for all custodial cases. The Eastern Shawnee Indian Child Welfare Department will be responsible in cases of exclusive jurisdiction.

The burial assistance benefit provides financial assistance to help pay for funeral, burial and/or cremation costs.

Allowable expenses include, but are not limited to:

Caskets >> Cemetery Plot >>Cemetery Tent/Equipment >> Cremation >> Death Certificate Copies >> Dressing & Cosmetics for Deceased >> Family Limousine >> Grave Markers >> Headstone >> Hearse >> Memorial Package >> Memorial Service >> Obituaries >> Pallbearers Car >> Professional Services >> Rental of Community Center >> Food Cost for Family Meal >> Cost for Bringing Body to the Home/Facility that Family Chooses >> Urn >> Vault Liner >> Viewing/Visitation Services

ELDER/DISABLED CARE benefits are available up to \$3,750 for eligible tribal members who meet the following requirements...

- ⇒ Must be an enrolled Eastern Shawnee tribal member 62 years of age or older
- ⇒ Receive benefits under Social Security Disability Income Program or Veteran's Disability
- ⇒ Have been diagnosed with a terminal illness

The elder/disabled care benefit provides assistance to enhance the quality of life for our tribal senior citizens and the fulfillment of the special needs and requirements that are unique to our disabled tribal members.

Allowable expenses include, but are not limited to:

Automobile Liability Insurance (2 vehicles) >> Healthcare Expenses >> Lawn Mowing (seasonal only) >> Removal of snow/ice from driveway >> Medic Alert/Lifeline Service >>Medicare Supplemental Insurance Premiums >> Primary Residence Homeowners Insurance >> Primary Residence Real Estate Property Taxes >> Rental Property Contents Insurance >> Utilities

Non-allowable expenses include, but are not limited to:

Automobile Insurance for Non-Licensed Members >> Auto Maintenance/Registration/Tags >> Brush Hogging >> Home/Garage/Outbuilding Repairs >> Household Appliance Purchase/Repair >> Internet/All telephone services >>Recreational Vehicle Insurance >> Tree Trimming/Removal

UTILITY benefits are available up to \$1,500 for eligible tribal members who meet the following requirements...

- ⇒ Must be an enrolled Eastern Shawnee member
- ⇒ Must be between the ages of 18—61 and not be disabled
- ⇒ Must be head of household
- ⇒ Applicants applying for membership will be eligible for utility benefits on or after date of enrollment. All utility statement service dates must be dated on or after enrollment date

The utility benefits is for your **primary** residence only. Primary residence is described as the dwelling where you usually live. The utility statement must have the same address as your residence.

If there is more than one Eastern Shawnee in the household, the rest of the tribal members **will not** be eligible for this benefit. If a tribal member resides at home with nontribal parent, the tribal member **will not** be eligible for this benefit.

If the utility statement is not in the tribal members name you will need to submit your marriage license or the landlord/roommate form.

The utility assistance program provides financial assistance to help reimburse paid monthly utility expenses.

Allowable expenses include, but are not limited to:

City Utilities >> Electric >> Firewood (Limit of 15 Ricks/5 Cords) >> Natural Gas >> Propane >> Trash Service >> Utility Hook-Up Deposit (A one-time Lifetime Coverage per utility) >> Water

Non-allowable expenses include, but are not limited to:

All telephone services >> Cable/Satellite >> Disconnection Notice Statements >> Finance Charges >> Internet >> Late Fee Penalties >> Monthly Rent/Deposits >> Past Due Balances >> Propane Tank Rental/Repairs >> Reconnection Fees >> Shut-Off Notice Statements

***Addendum: While the Health & Social Service Program operates on the fiscal year (October 1—September 30) this will have no impact on utility assistance reimbursements. No utility will be denied because of the September 30th cut-off date, allowing you to submit a continuous year of utilities. Subject to the availability of funds, you will receive reimbursement for that utility regardless of the fiscal year end as long as you submit your claim within 90 days from the billing date.

REIMBURSEMENT REQUEST

This Claim Form with original itemized bills & receipts and all correspondence should be mailed to:

HEALTH & SOCIAL SERVICES

10100 S. Bluejacket Rd., Ste. 1

Wyandotte OK 74370

Within 90 days of the date you first received your expenses

DO NOT submit a claim unless your total expenses meet the \$25 minimum requirement

Please complete all relevant sections of this form. Original documentation (itemized bills & receipts) must be submitted with this form. Photocopies of documents are NOT acceptable.

PLEASE NOTE: All claims must be incurred during the fiscal year (Oct 1—Sep 30.) Processing time could be delayed if proper documentation is not provided.

****IMPORTANT: For any questions about the program please call us at (918) 666-7710 or toll free at (866) 978-1352****

TRIBAL MEMBER INFORMATION (ONLY ONE MEMBER PER FORM)

Name: _____	Tribal ID #: _____
Address: _____	Date of Birth: _____
_____	Address Change <input type="checkbox"/>
E-Mail Address: _____	Work <input type="checkbox"/> Home <input type="checkbox"/> New <input type="checkbox"/>
Phone Number Where You May Be Reached: () - _____	Telephone Change <input type="checkbox"/>

LIST ELIGIBLE SERVICES AND EXPENSES FOR YOU AND YOUR FAMILY THAT YOU HAVE NOT ALREADY CLAIMED THROUGH ANY INSURANCE, MEDICARE OR MEDICAID PLAN. ONLY LIST THE AMOUNT OF THE EXPENSES YOU HAVE TO PAY AFTER INSURANCE PAYS ITS SHARE. *PLEASE DO NOT USE HIGHLIGHTER, STAPLES OR TAPE RECEIPTS.

<u>Types of Expenses</u>	<u>Dates Incurred</u>	<u>Total Out-of-Pocket Expenses</u>
Total School Expense Reimbursement Requested	From _____ To _____	\$ _____
Total Health Care Reimbursement Requested	From _____ To _____	\$ _____
Total Orthodontic Reimbursement Requested	From _____ To _____	\$ _____
Total Auditory Devices Reimbursement Requested	From _____ To _____	\$ _____
Total Special Medical Equipment Reimbursement Requested	From _____ To _____	\$ _____
Total Burial Reimbursement Requested	From _____ To _____	\$ _____
Total Disabled/Elder Care Reimbursement Requested	From _____ To _____	\$ _____
Total Utilities Reimbursement Requested	From _____ To _____	\$ _____
Total Reimbursement Requested		\$ _____

***** IF ANY OF THESE EXPENSES WERE COVERED BY INSURANCE, ATTACH A COPY OF THE EXPLANATION OF BENEFITS FROM YOUR INSURANCE COMPANY SHOWING YOUR OUT-OF-POCKET EXPENSES, WITH PROOF OF PAYMENT. FOR EXPENSES NOT COVERED BY INSURANCE, SEND THE ORIGINAL ITEMIZED STATEMENT IDENTIFYING THE SERVICE, SERVICE DATE, TOTAL CHARGES AND ANY DISCOUNTS. IF THE REQUIRED DOCUMENTATION IS NOT ATTACHED, YOUR REIMBURSEMENT WILL BE DELAYED.**

CERTIFICATION: Signature Required *(Parent or Guardian in case of minor child)

I certify that the above expenses were incurred by me (and/or my spouse and/or eligible dependents) and have been incurred within the current fiscal year and were not reimbursed by any other plan, and to the best of my knowledge and belief, are eligible for reimbursement. I have attached proof of school enrollment and documentation from the school (when necessary) and the Explanation of Benefits statements from all insurance plans and a letter of medical necessity (when necessary) of these expenses.

Tribal Members Signature: _____ Date: _____

Did you remember to:

*Sign and date your reimbursement form

*Attach your receipts

*Provide proper documentation

*Make copies of all documentation for your records

Failure to complete all appropriate sections of the reimbursement form or submit legible itemized receipts/EOBs may delay the processing of your claim and may result in your claim being returned to you.

**DIRECT TO VENDOR PAYMENT
HEALTH EXPENSE CLAIM FORM**

Contact Health & Social Services at: 918-666-7710 or 866-978-1352

Mail to: 10100 S. Bluejacket Rd., Ste. 1, Wyandotte OK 74370

Tribal Member Information		
Tribal Member's Name :	DOB:	ID#:
Phone Number Where You May Be Reached : () -		<input type="checkbox"/> New
E-mail Address :	<input type="checkbox"/> Work	<input type="checkbox"/> Home <input type="checkbox"/> New
Mailing Address :		<input type="checkbox"/> Address Change

Insurance Information
Is member covered under any health insurance plan ? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes complete the following:
Name of Policy Holder _____
Name & Address of Insuring Company _____
I.D. Number _____
Is member covered under any Medicaid coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes list state covered in: _____

Medicare Information
Name of Medicare Beneficiary _____ Medicare Number _____
Type of Coverage: Part A (Hospital) Effective Date _____
Part B (Medical) Effective Date _____
Part D (Drug) Effective Date _____

Direct to Vendor Request			
Complete the following grid for each medical expense submitted for a direct to vendor payment for you and/or your dependents. In order to receive payment, appropriate supporting documentation must accompany this form. Please do not hesitate to contact Social Services to confirm necessary documentation, timing requirements and rules for eligible expenses. Attach the original bill or statement from the physician or supplier and keep a copy for your records. Sign this form. Minimum amount of claim is \$25.00.			
Name of Service Provider	Description of Medical Service	Date of Service	Amount of Claim
			\$
			\$
			\$

I, the undersigned, furnished the above information to enable Eastern Shawnee Health & Social Services to consider this claim for payment, and I certify that such information is true and correct and that the expenses were incurred by the above named patient. **I understand that any payment will be made to the vendor.**

Signature _____ Date _____

COORDINATION OF BENEFITS QUESTIONNAIRE

It is important that you complete and return this survey. Coordination of benefits is a way to coordinate benefit payments when you or your dependents are covered by a health plan. By keeping us informed, we can update your records and provide you with timely and accurate processing of claims. Please answer all questions completely. Thank you.

Are you, your spouse, or any of your dependents covered by a health plan, Medicaid or Medicare? Yes No

If yes: - For health insurance and Medicaid plans, please complete sections 1 & 2.

- For Medicare coverage only, please complete sections 1 & 3.

- For other health insurance plans and Medicare, complete sections 1, 2 & 3.

If no: - Please complete section 1 and sign your name.

PLEASE PRINT

SECTION 1—TO BE COMPLETED BY ALL TRIBAL MEMBERS			
Tribal Members' Name	Birth Date	Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	State for Medicaid coverage
Tribal Members' Roll Number	Phone Number Where You May Be Reached	Today's Date	
SECTION 2—OTHER COVERAGE INFORMATION			
Name of Policyholder	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date	Relationship to You
Name of Health Plan		Policyholder Identification Number	
Health Plan's Address		Phone Number	
Employment Status <input type="checkbox"/> Active <input type="checkbox"/> Retired	Employer's Name		
Type of Coverage	<input type="checkbox"/> Medical	<input type="checkbox"/> Rx	<input type="checkbox"/> Dental <input type="checkbox"/> Vision
Effective Date	_____	_____	_____
Cancellation Date	_____	_____	_____
Please list any other dependents covered by this plan. If there are more than four, please check this box <input type="checkbox"/> and list the rest on the back of this form.			
1. Name (First and Last)	Relationship to You	3. Name (First and Last)	Relationship to You
2. Name (First and Last)	Relationship to You	4. Name (First and Last)	Relationship to You
SECTION 3—MEDICARE COVERAGE INFORMATION			
Name of Medicare Beneficiary			
Medicare Number _____	Type of Coverage Part A (Hospital) Effective Date _____ Part B (Medical) Effective Date _____ Part D (Drug) Effective Date _____	Medicare Eligibility Due to: <input type="checkbox"/> Age <input type="checkbox"/> Disability <input type="checkbox"/> End-Stage Renal Disease Initial Dialysis Date _____	
MAIL FORM TO: HEALTH & SOCIAL SERVICES 10100 S. BLUEJACKET RD., STE. 1, WYANDOTTE OK 74370			

PRE-AUTHORIZATION OF TREATMENT REQUEST

FOR PROVIDER USE							
PROVIDER PHONE () _____	PROVIDER FAX () _____						
PROVIDER NAME AND ADDRESS <i>(Please Attach W-9 Tax Form)</i>							
PATIENT NAME AND ADDRESS Phone _____	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; padding: 5px;"> Sex <input type="checkbox"/> </td> <td style="width: 50%; padding: 5px;"> Age <input type="text"/> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/> </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Tribal Roll # <input type="text"/> </td> </tr> </table>	Sex <input type="checkbox"/>	Age <input type="text"/>	Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>		Tribal Roll # <input type="text"/>	
Sex <input type="checkbox"/>	Age <input type="text"/>						
Date of Birth <input type="text"/> / <input type="text"/> / <input type="text"/>							
Tribal Roll # <input type="text"/>							
OFFICE USE ONLY							
TREATMENT PLAN ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____							
EOB ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____							
BENEFITS QUESTIONNAIRE ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____							
PAY PER REQUEST. SERVICES WERE PROVIDED ON _____ . TOTAL AMOUNT DUE _____ .							
PROVIDER, YOUR REQUEST IS: <input type="checkbox"/> APPROVED AS REQUESTED—\$ _____ <input type="checkbox"/> APPROVED AS MODIFIED— \$ _____ <input type="checkbox"/> NON-APPROVED AS REQUESTED <input type="checkbox"/> PAY TO VENDOR— \$ _____ By _____ Date _____ Comments/Explanation: _____ _____ _____ _____ _____							
SERVICE DESCRIPTION: _____ MEDICAL JUSTIFICATION: _____ _____ _____ _____							

NO PAYMENT WILL BE ISSUED FOR SERVICES WITHOUT AUTHORIZATION. AUTHORIZATION DOES NOT GUARANTEE PAYMENT. PAYMENT IS SUBJECT TO PATIENT'S ELIGIBILITY. HEALTH & SOCIAL SERVICES IS A TRIBAL BENEFIT AND SHOULD NOT BE TREATED AS PATIENT'S INSURANCE. AS THEIR MEDICAL PROVIDER, YOU MUST FILE WITH PATIENT'S INSURANCE FIRST AND THEN FILE WITH SOCIAL SERVICES. ALL INVOICES WITH BILLING MUST BE SUBMITTED WITHIN 90-DAYS OF THE DATE OF SERVICE OR UPON INSURANCE PAYMENT. JUNE THROUGH SEPTEMBER BILLINGS MUST BE RECEIVED BY SEPTEMBER 30TH, THE END OF OUR FISCAL YEAR.

Contact Information: Eastern Shawnee Tribe of Oklahoma
 Health & Social Services
 10100 S. Bluejacket Rd., Ste. 1
 Wyandotte OK 74370
 Phone: (918) 666-7710
 Fax: (918) 666-7714

Contact Person: Cheryl Tallman
 Phone Ext. 1116

FILING A REIMBURSEMENT CLAIM

- ◆ Please separate all receipts for each family member. A separate reimbursement form is needed for each person. Documentation must include service dates, service description and charges for services received. Do not attach a balance forward bill, cut-off and/or shut-off notices or collection agency letters.
- ◆ Combine all like reimbursement requests. For example, if you are submitting several health care receipts for reimbursement, enter the range of dates over which the purchases were made and the total of all the receipts on the health care line:

Total Health Care Reimbursement Requested From: 4/1/12 To: 4/16/12 \$234.56

- ◆ Service dates must be within the fiscal year (Oct 1—Sep 30) to be eligible expenses.
- ◆ If your claim is covered by insurance, an explanation of benefits must accompany the reimbursement form along with your statement and/or a receipt that clearly identifies your co-pay amount.
- ◆ If the reimbursement requested is not covered by insurance, the reimbursement form must be accompanied by a bill or receipt showing date, service and charges. This is adequate documentation of the expense, as long as there is no reference to insurance coverage on the bill or receipt.

REIMBURSEMENT REQUEST CHECKLIST

	Reimbursement Form	Itemized Invoice or Statement	Explanation of Benefits	Co-Pay Receipt	Itemized Cash Register Receipt or Other Proof of Payment
⇒ Insured Expenses					
Health Care	✓	✓	✓	✓	
Orthodontics	✓	✓	✓	✓	
Auditory Devices	✓	✓	✓	✓	
Special Medical Equipment	✓	✓	✓	✓	
Disabled/Elder Care	✓	✓	✓	✓	
Burial	✓	✓			
⇒ Uninsured Expenses					
Health Care	✓	✓			✓
Orthodontics	✓	✓			✓
Auditory Devices	✓	✓			✓
Special Medical Equipment	✓	✓			✓
Disabled/Elder Care	✓	✓			✓
School Expenses	✓				✓
Utilities	✓	✓			✓
Burial	✓	✓			✓

We will make every effort to process your claim promptly and accurately. However, we need your assistance to ensure that the information you send us is complete so there will be no delay processing your claim that may result in your claim being returned to you.

**AUTHORIZATION TO RELEASE INFORMATION
TO THE EASTERN SHAWNEE TRIBE OF OKLAHOMA
HEALTH & SOCIAL SERVICE DEPARTMENT**

THIS FORM MUST BE COMPLETED AND ON FILE BEFORE ANY SERVICES WILL BE CONSIDERED

Please list all individuals living in the household — —

Family Member	Relationship	Social Security #	Sex	Date of Birth	Roll #

I hereby give permission for the Eastern Shawnee Tribe, teacher or school, physician, dentist, optometrist, energy company, hospital or any other organization, healthcare provider or persons providing service to me and maintaining information about me to release information to the Health and Social Service Department. This information shall include verification that the patient was seen on a certain day, whether a healthcare insurance company or other party was billed for the service rendered and documentation of any payments received, the dates that said patient received medical treatment or otherwise from the healthcare provider and an original bill and/or original itemized statement for services rendered to the patient. The Health and Social Service Department requests such information for the purpose of determining eligibility for social services and legitimacy of claims.

I understand that I have the right to revoke this authorization at any time by written notice to the Eastern Shawnee Health and Social Service Department at 10100 S. Bluejacket Rd., Ste. 1, Wyandotte OK 74370. I am aware that my revocation of this authorization will not be effective to the extent the persons and/or organizations identified above have already acted in reliance upon this authorization. I understand that my revocation of this authorization may prevent or delay me from receiving services from the Eastern Shawnee Health and Social Service Department.

I have read, understand and agree to comply with the requirements of eligibility for the Health and Social Service Department of the Eastern Shawnee Tribe of Oklahoma. I also understand that the guidelines are set forth for the fair and equal treatment of each enrolled tribal member of the Eastern Shawnee Tribe of Oklahoma. If any of the above information changes, it is my responsibility to notify the Eastern Shawnee Health and Social Service Department in writing.

This authorization must be signed by each tribal member (or the tribal members parent or legal guardian if the tribal member is a minor) identified in the above table.

TRIBAL MEMBERS SIGNATURE	PRINT NAME OF TRIBAL MEMBER	DATE

I am the parent and/or legal guardian of the minors identified below and executes this authorization on their behalf.

(Please print names of minor children)

_____	_____
_____	_____
_____	_____

Head of Household _____

Address _____

City/State/Zip _____

Daytime Phone _____

***SUBMITTING FRAUDULENT CLAIMS IS A FEDERAL CRIME UNDER 18 CFR PART 1 CHAPTER 53 §1163.
PRIVACY AND CONFIDENTIALITY IS PROTECTED UNDER 42 CFR.***

3/1/2009

AUTHORITY TO RELEASE INFORMATION TO A DESIGNATED INDIVIDUAL

Complete this form if you authorize Eastern Shawnee Tribe of Oklahoma’s Health & Social Service Program to release information to someone other than yourself. The individual you designate will be able to acquire and receive information such as the status of your claim and benefit balance. Please inform this individual to allow 30 days from your submission before calling the department inquiring as to the status.

Choose One

- I authorize Eastern Shawnee Tribe of Oklahoma’s Health & Social Service Program to release information from my Health & Social Service records to the following individual.
- I withdraw my authorization to release information from my Health & Social Service records to the following individual.

Your Designated Individual’s Full Name

Address

**City, State,
Zip**

Telephone

**Relationship
to Yourself**

Name

Birth Date

Tribal ID #

I authorize the release of this information to the person named above for the following period of time:

From: ____ / ____ / ____ To: ____ / ____ / ____

If you are giving your authorization — I authorize the Eastern Shawnee Tribe of Oklahoma’s Health & Social Service Program to release information from my Health & Social Service records to the individual named above. I am aware that some information may not be released if it is subject to the Privacy Act. I am aware that this form is to protect my confidentiality.

If you are withdrawing your authorization — I withdraw my authorization to release information from my Health & Social Service records to the individual named above.

Signature of Tribal Member

Signature of Designated Individual

Date _____

Date _____

LANDLORD OR ROOMMATE

UTILITY ASSISTANCE

INFORMATION FORM

(This form must be completed by the landlord or roommate)

Name of tribal member (tenant): _____

Billing information as it appears on the utility statement:

Name: _____

Address: _____

Relationship to tribal member: _____

How long has tribal member been at this residence: _____

Are utilities included with rent cost? Yes _____ No _____

If yes, please breakdown cost for each utility charged: _____

Lease/rental agreement attached. Yes _____ No _____

If not, please explain: _____

How many residents reside at this residence? _____

Landlord/Roommate Signature: _____ Date: _____

(Whose name appears on the utility bills)

Telephone Number Where You May Be Reached: _____

Tribal Members Signature: _____ Date: _____

Please submit utility statements with proof of payment from tribal member, i.e. money order, cashier's check or cancelled check (front & back) and mail to:

Eastern Shawnee Health & Social Service Department

10100 S. Bluejacket Rd., Ste. 1

Wyandotte OK 74370

Any questions, feel free to contact the department at 918-666-7710.