

PRE-AUTHORIZATION OF TREATMENT REQUEST

FOR PROVIDER USE		
PROVIDER PHONE <input style="width: 90%;" type="text"/>	PROVIDER FAX <input style="width: 90%;" type="text"/>	TREATMENT PLAN ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____
PROVIDER NAME AND ADDRESS <i>(Please Attach W-9 Tax Form)</i>		EOB ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____
PATIENT NAME AND ADDRESS Phone _____		BENEFITS QUESTIONNAIRE ATTACHED: YES <input type="checkbox"/> NO <input type="checkbox"/> IF NO, EXPLAIN _____ _____
Sex <input type="checkbox"/> Age <input type="text"/> Date of Birth <input style="width: 100%;" type="text"/> Tribal Roll # <input style="width: 100%;" type="text"/>		PAY PER REQUEST. SERVICES WERE PROVIDED ON _____ . TOTAL AMOUNT DUE _____ .
OFFICE USE ONLY		
SERVICE DESCRIPTION: _____ MEDICAL JUSTIFICATION: _____ _____ _____ _____		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: _____ _____ _____ _____ _____

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) 666-7715

Contact Person: Cheryl Tallman
 Phone Ext. 1116