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 : ( ) -		☐ New
E-mail Address :	☐ Work ☐ Home	☐ New
Mailing Address :		☐ Address Change

Insurance Information

Is member covered under any health insurance plan ? ☐ Yes ☐ 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? ☐ Yes ☐ 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 _____