HEALTH & SOCIAL SERVICE BENEFIT CLAIM FORM

Please mail this form and the supporting documentation to:

Health & Social Services
10100 S. Bluejacket Rd., Ste. 1
Wyandotte OK 74370

TRIBAL MEMBER HEAD OF HOUSEHOLD INFORMATION	
	Tribal ID#
	Date of Birth
	E-mail
	Cell #
	Home #
	Work #

Name	
Mailing Address	
City, State, Zip	

UTILITIES	Members' Name	Date of Service	Amount
City			
Electricity			
Firewood			
Natural Gas/Propane			
Sewer			
Trash			
Water			
Subtotal			$ 0.00

HEALTH CARE	Members' Name	Date of Service	Amount
Dental			
Eye Care			
Medical			
Rx			
Subtotal			$ 0.00

SCHOOL EXPENSES	Members' Name	Date of Service	Amount
Clothing			
Driver's education			
Testing fees			
Traditional supplies			
Subtotal			$ 0.00

MEDICAL EQUIPMENT	Members' Name	Date of Service	Amount
Blood pressure unit			
Cane/crutch/walker			
Diabetic supplies			
Grab bar/safety rails			
Lift chair			
Medic alert/lifeline			
Respiratory supplies			
Scooter/wheelchair			
Other			
Subtotal			$ 0.00

TOTAL REIMBURSEMENT REQUESTED	$ 0.00

DISABLED/ELDER CARE	Members' Name	Date of Service	Amount
Auto Liability Insurance			
City utility			
Electricity			
Firewood			
Healthcare			
Lawn mowing			
Medicare medical insurance			
Natural Gas/Propane			
Main residence home ins.			
Main residence property tax			
Rental property contents ins.			
Trash			
Water			
Other			
Subtotal			$ 0.00

BURIAL	Members' Name	Date of Service	Amount
Cemetery plot			
Cremation			
Funeral home expenses			
Grave marker/headstone			
Professional services			
Urn			
Subtotal			$ 0.00

ORTHODONTICS	Members' Name	Date of Service	Amount
Braces			
Subtotal			$ 0.00

AUDITORY	Members' Name	Date of Service	Amount
Doctor visits/tests			
Fitting fees/batteries			
Hearing aids			
Subtotal			$ 0.00

All claims must be submitted within 90-days from date of service & total reimbursement requested must meet the $25 minimum requirement

The above expenses for which I am requesting reimbursement are for myself or my eligible dependents, are within the current fiscal year and were not reimbursed by any other plan. I have attached all supporting documentation of these expenses in good faith and to the best of my knowledge are eligible for reimbursement.

Tribal Members' Signature*: _____ Date: _____

*The tribal member's signature & date are required in order to process your claim for reimbursement.