DEPARTMENT OF HEALTH AND HUMAN SERVICES

US PUBLIC HEALTH SERVICE – INDIAN HEALTH SERVICE (IHS)
INDIVIDUAL APPLICATION FOR HEALTH CARE SERVICES

LEGAL NAME OF PATIENT:

_____
Last, First Middle Name

MAILING ADDRESS: _____

_____
City, State, Zip

BIRTH DATE: _____/_____/_____

MALE ☐ **FEMALE** ☐ **MARITAL STATUS:** _____

TRIBE ENROLLED: _____

TRIBE BLOOD QUANTUM: _____

TOTAL BLOOD QUANTUM: _____

MIGRANT WORKER: ☐ **YES** ☐ **NO**

HOMELESS: ☐ **YES** ☐ **NO**

BIRTH PLACE: City_____ **State**_____

SOCIAL SECURITY NUMBER: _____ / ___ / _____

Do you go by any OTHER NAME? If so please list:

_____

HOME PHONE NO._____

WORK PHONE NO._____

EMPLOYER: _____

FATHER'S NAME: _____

MOTHER'S MAIDEN NAME: _____
Last, First MN

Emergency Contact Name and Relationship to applicant:

NAME: _____

RELATIONSHIP: _____

ADDRESS: _____

_____

PHONE #: _____

RACE: ☐ **AMERICAN INDIAN/ ALASKAN NATIVE** ☐ **NATIVE HAWAIIAN/PACIFIC ISLANDER** ☐ **ASIAN** ☐ **BLACK/AFRICAN AMERICAN** ☐ **WHITE/CAUCASIAN** ☐ **UNKNOWN** ☐ **I DECLINE TO ANSWER**

ETHNICITY: ☐ **HISPANIC OR LATINO** ☐ **NON-HISPANIC OR LATINO** ☐ **DECLINE TO ANSWER** ☐ **UNKNOWN**

PRIMARY LANGUAGE:_____ **HOW WELL?:** ☐ **VERY WELL** ☐ **WELL** ☐ **NOT WELL** ☐ **NOT AT ALL**

VETERAN: ☐ **YES** ☐ **NO** **BRANCH OF SERVICE:** _____

DATE ENTERED: _____ **DATE DISCHARGED:** _____ **SERVICE CONNECTED:** _____ **VIETNAM SERVICE?** ☐ **YES** ☐ **NO**

DO YOU HAVE INTERNET ACCESS? YES NO **WHERE?** HOME-WORK-SCHOOL-LIBRARY-TRIBAL COMM CTR

E-MAIL ADDRESS? _____

DO YOU HAVE MEDICAL INSURANCE? YES ☐ NO ☐ *** **DO YOU HAVE DENTAL INSURANCE?** YES ☐ NO ☐

(Copy front & back of Insurance cards –Attach to Application)

INSURANCE COMPANY'S NAME: _____**Effective Date**_____

INSURANCE COMPANY'S ADDRESS: _____

CITY, STATE, and ZIP: _____ **PHONE NO.**_____

POLICY HOLDER'S NAME: _____ **POLICY HOLDER'S DATE OF BIRTH:** _____

GROUP NUMBER: _____ **GROUP NAME:** _____**POLICY HOLDER'S SSN NUMBER** _____

POLICY HOLDER'S EMPLOYER_____ **EMPLOYER TELEPHONE NUMBER**_____

EMPLOYER ADDRESS_____**CITY, STATE, ZIP:** _____

MEDICARE NO: _____**PART A:** _____ **Effective Date**_____ **PART B** _____ **Effective Date:** _____

MEDICAID NO: _____ **Effective Date:** _____ (attach copy of card)

****** SIGNATURES REQUIRED ON THE BACK ****** **IHS #** _____

Hoh Purchase and Referred Care
1414 NW Northrup, Suite 800
Portland, Oregon 97209

I UNDERSTAND THAT THE INFORMATION I HAVE GIVEN TO IHS IS CORRECT AND TRUE TO THE BEST OF MY KNOWLEDGE.

X

PATIENT, LEGAL GUARDIAN, OR POWER OF ATTORNEY DATE

AUTHORIZATION TO FURNISH INFORMATION

IHS MAY DISCLOSE ALL OR ANY PART OF THE PATIENT'S RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE FOR ALL OR PART OF THE VENDOR'S CHARGES FOR CARE; INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICE COMPANIES, INSURANCE COMPANIES, WORKMEN COMPENSATION CARRIERS, WELFARE AGENCIES, OR THE PATIENT'S EMPLOYER.

HOWEVER, A SPECIAL CONSENT MUST BE GRANTED BY THE PATIENT FOR ANY INFORMATION REGARDING CARE OF TREATMENT FOR ALCOHOL ABUSE, DRUG ABUSE, OR CONDITIONS RELATED SPECIFICALLY TO ALCOHOL OR DRUG ABUSE.

ASSIGNMENT OF BENEFITS

I AGREE THAT IHS MAY SEEK INSURANCE BENEFITS THAT I MAY HAVE PERTAINING TO PAYMENT FOR ALL SERVICES AND SUPPLIES, THAT THIS ASSIGNMENT APPLIES TO ALL SERVICES AND SUPPLIES FURNISHED TO ME BY IHS DURING A PERIOD OF HOSPITALIZATION OR OUTPATIENT VISITS, INCLUDING EMERGENCY ROOM SERVICES.

SUBMISSION OF ELECTRONIC CLAIMS AND CONFIDENTIALITY OF CLIENT INFORMATION

ALL INFORMATION AS TO PERSONAL FACTS AND CIRCUMSTANCES OBTAINED BY THE FACILITY ON THE PATIENT SHALL BE TREATED AS PRIVILEGED COMMUNICATIONS, SHALL BE HELD CONFIDENTIAL, AND SHALL NOT BE DIVULGED WITHOUT THE WRITTEN CONSENT OF THE CLIENT, HIS OR HER ATTORNEY, THE RESPONSIBLE PARENT OF A MINOR CHILD, OR HIS OR HER GUARDIAN. NOTHING PROHIBITS THE DISCLOSURE OF INFORMATION IN SUMMARIES, STATISTICAL, OR OTHER FORM, WHICH DOES NOT IDENTIFY PARTICULAR INDIVIDUALS.

THE USE, OR DISCLOSURE OF INFORMATION CONCERNING PATIENTS SHALL BE LIMITED TO PERSONS DIRECTLY CONNECTED WITH THE SUBMISSION OF ELECTRONIC CLAIMS. CONFIDENTIALITY POLICIES SHALL BE APPLIED TO ALL REQUESTS FROM OUTSIDE SOURCES.

X

PATIENT, LEGAL GUARDIAN, OR POLICY HOLDER'S SIGNATURE FOR PRIVATE INSURANCE DATE

PRINT FULL LEGAL NAME