PATIENT ELIGIBILITY PACKET

2740 Herndon Avenue • Clovis, CA 93611-6813 • Phone: (559) 299-2578 • Fax: (559) 299-0245

Central Valley Indian Health, Inc.

Documents Required by CVIH in order to verify Eligibility

All Patients:

1. Registration form
2. Photo Identification (for everyone 18 or older)
3. Social Security Number (for everyone)
4. Alternate Resource Determination Form
    a. Provide copy of Insurance, Medi-Cal or Medicare card, if applicable

Direct Care, all of the above plus the following:

5. County Certificate of Live Birth (Only if documentation is not your own. Need all CLB's up to the documented Native American)
6. Family Tree (Only if documentation is not your own. Up to the documented Native American).
7. Bureau of Indian Affairs (BIA) Letter or Tribal Documents (Tribal card or letter)

Purchased Referred Care, all of the above plus the following:

8. Must live in Fresno, Madera or Kings Counties for Purchased Referred Care Services
9. Purchased Referred Care Notification of Pharmacy Benefits
10. Important Notice for Medicare Beneficiaries with Purchased Referred Care
11. Purchased Referred Care Referral Guide

Patients must comply with alternate resource requirements within **45 days**.
All missing documents must be supplied within **60 days** of the date of your first visit.

For additional information please visit our web site at: www.cvih.org.

Thank you!

2740 Herndon Avenue Clovis, CA 93611 Phone: 559-299-2578 Ext. 1812 Fax: 559-862-2744

__CLOVIS ____MED __DEN
__PRATHER ____MED __DEN
___NORTH FORK____MED __DEN
__TACHI____MED __DEN

DO YOU HAVE ANY SPEICAL NEEDS?
____SIGHT ___ HEARING
_____AMBULATORY
____ SPEECH

CENTRAL VALLEY INDIAN HEALTH
PATIENT REGISTRATION

PATIENT INFORMATION **PATIENT NO:_____**
LEGAL LAST NAME: **FIRST:** **MIDDLE:**
DATE OF BIRTH: **CITY OF BIRTH:** **STATE OF BIRTH:**
SEX: **SOCIAL SECURITY NUMBER:**
MARITAL STATUS: ___SINGLE __MARRIED ___DIVORCE ___WIDOWED ___SEPARATED
MAILING ADDRESS:
CITY: **STATE:** **ZIP CODE:**
STREET ADDRESS (IF DIFFERENT FORM MAILING ADDRESS):
CITY: **STATE:** **ZIP CODE:**
HOME PHONE# **CELL PHONE#:**
DATE MOVED TO PRESENT COMMUNITY:
INTERNET ACCESS: _____YES _____NO WHERE:_____
EMPLOYMENT STATUS: __UNEMPLOYED __FULL-TIME __PART-TIME __SELF EMPLOYED __RETIRED
(PARENT FOR CHILD)
(FATHER'S) **EMPLOYER NAME:** **PHONE NUMBER:**
EMPLOYERS ADDRESS:
CITY: **STATE:** **ZIP CODE:**
(MOTHER'S) **SPOUSE'S EMPLOYER NAME:**
SPOUSE'S EMPLOYER ADDRESS:
CITY: **STATE:** **ZIP CODE:**
RACE: __WHITE __ASIAN __BLACK __FILIPINO __HISPANIC/LATINO __PACIFIC ISLANDER __INDIAN/ALASKAN NATIVE
ELIGIBILITY/RELIGION/TRIBAL DATA
RELIGIOUS PREFERENCE (OPTIONAL):
TRIBE OF MEMBERSHIP:
INDIAN BLOOD QUANTUM:
FATHER'S NAME:
FATHER'S CITY & STATE OF BIRTH: **TRIBE:**
MOTHER'S NAME: **MOTHER'S MAIDEN NAME:**
MOTHER'S CITY AND STATE OF BIRTH: **TRIBE:**
TRIBE ADDRESS:
CITY: **STATE:** **ZIP CODE:**
NAME OF RESERVATION:
OTHER TRIBE INFORMATION:
PLEASE PROVIDE COPY OF TRIBAL VERIFICATION (TRIBAL ID CARD, LETTER FORM BIA, ETC.) **(Rev.3/07**

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____ SPEECH

CENTRAL VALLEY INDIAN HEALTH
PATIENT REGISTRATION

EMERGENCY CONTACT (IF CHILD, PLEASE FILL-IN PARENT/GUARDIAN NAME)		
EMERGENCY CONTACT:		
EC PHONE:	**EC RELATIONSHIP:**	
EC ADDRESS-STREET:		
EC ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
INSURANCE INFORMATION		
DO YOU HAVE MEDICARE? YES NO	**DO YOU HAVE MEDI-CAL? YES NO**	
DO YOU HAVE PRIVATE INSURANCE? YES NO		
NAME:	**POLICY#**	**SUBSCRIBER:**
DOB:	**SOC. SEC. NUMBER:**	
ATTACH COPY OF MEDI-CAL, MEDI-CARE OR INSURANCE CARDS		
NEXT OF KIN: (ENTER SAME IF SAME PERSON AS EMERGENCY CONTACT)		
NOK NAME:		
NOK PHONE:		
NOK ADDRESS-STREET:		
NOK ADDRESS-CITY:	**STATE:**	**ZIP CODE:**
VETERAN'S INFORMATION		
VETERAN? YES NO	**SERVICE BRANCH (LAST)?**	
	SERVICE ENTRY DATE (LAST)?	
SERVICE SEPARATION DATE (LAST)?		
VIETNAM SERVICE INDICATED?		
SERVICE CONNECTED?	**CLAIM NUMBER:**	
DESCRIPTION OF VA DISABILITY:		
VALID VA CARD?		
ASSIGNMENT AND RELEASE		

AUTHORIZATIONS FOR RELEASE OF INFORMATION AND ASSIGNMENT OF INSURANCE BENEFITS.
I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING DIAGNOSIS OF A MEDICAL CONDITION FOR THE SOLE PURPOSE OF SUBMISSION OF CLAIMS TO THIRD PARTY BILLING INSURANCE CARRIERS. I FURTHER AUTHORIZE CENTRAL VALLEY INDIAN HEALTH TO RELEASE ANY INFORMATION REQUIRED IN THE PROCESS OF THIS CLAIM. I HERBY ASSIGN ANY INSURANCE BENEFITS TO CENTRAL VALLEY INDIAN HEALTH AND AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO CENTRAL VALLEY INDIAN HEALTH. I UNDERSTAND I AM FINANCIALLY RESPONSIBLE FOR THE DEDUCTIBLE, CO-PAYMENT AND CHARGES NOT COVERED BY SAID INSURANCE OR GOVERNMENT AGENCY.
I HEREBY DECLARE THAT I HAVE READ THE PATIENT REGISTRATION FORM, AND KNOW AND UNDERSTAND THE CONTENTS THEREOF AND THAT THE INFORMATION PROVIDED ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

DATE: SIGNATURE OF PATIENT OR GUARDIAN:

OFFICE USE:	
RECEIVED INSURANCE CARD: YES NO	RECEIVED INDIAN VERIFICATION: YES NO
TYPE OF VERIFICATION:	
ENTERED INTO SYSTEM ON:	ENTERED BY:
APPROVED FOR (CIRCLE ONE) DC CC	REGISTRATION COMPLETE: YES NO
MISSING DOCUMENTS:	

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CENTRAL VALLEY INDIAN HEALTH
PATIENT REGISTRATION

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CENTRAL VALLEY INDIAN HEALTH
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CENTRAL VALLEY INDIAN HEALTH
PATIENT REGISTRATION

DO YOU HAVE ANY SPEICAL NEEDS?
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____ SPEECH

Central Valley Indian Health Inc.,
2740 Herndon Av, Clovis, CA 93611
(559) 299-3262 Ext. 1811

Patient Requirement for Alternate Resource Determination

Date: _____ Date of Birth: _____

Patient Name: _____

Address: _____ City/Sate/Zip: _____

Home Phone: _____ Cell: _____

This information is necessary pursuit to Indian Health Services Regulations, 42 CFR, Subpart G, paragraph C. You must provide this facility with a copy of the alternate resource's eligibility determination.

Please check the line pertains to you the patient:

YES _____ NO _____ Do you have Covered California?

YES _____ NO _____ Do you have Medi – Cal?

YES _____ NO _____ Do you have Medicare?

YES _____ NO _____ Do you have private health insurance, including Kaiser Insurance?

- If you answered YES to any of the above question, please give your card to the Medical Receptionist to copy for your file.
- If you answered No to all of the above questions, you will need to be screened by the Patient Service Representative at 299-3262 Ext. 1811. You can also apply at the Social Service office in the county you reside, online or with our Patient Representative.
- If you are employed, we need a statement from your employer stating that you do not have medical insurance.
- If you need assistance, please contact CVIH Patient Services Representative. You will have 45 days to complete the necessary information and return to the PRC Eligibility Office.
  If no information is returned, and there is no request for assistance, a PRC denial letter will be issued.

Sincerely,

Central Valley Indian Health

CVIH FAMILY TREE

Date: _____

_____
Applicant's Name

_____
Date of Birth

_____
Current Home Address

_____
State, Zip Code

_____
Phone Number

Is Applicant Adopted?
Yes / No

Are Parent's Adopted?
Yes / No

If, yes list biological parents:
_____

FATHER

Name: _____
Tribe: _____
Roll #: _____
Deceased: Yes / No Year:
Date of Birth: _____

MOTHER

Name: _____
Tribe: _____
Roll #: _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Grandfather

Name: _____
Tribe: _____
Roll # _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Grandmother

Name: _____
Tribe: _____
Roll# _____
Deceased: Yes / No Year:
Date of Birth: _____

Maternal Grandfather

Name: _____
Tribe: _____
Roll# _____
Deceased: Yes / No Year:
Date of Birth: _____

Maternal Grandmother

Name: _____
Tribe: _____
Roll# _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Great Grandfather

Name: _____
Tribe: _____
Roll# _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Great Grandmother

Name: _____
Tribe: _____
Roll # _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Great Grandfather

Name: _____
Tribe: _____
Roll # _____
Deceased: Yes / No Year:
Date of Birth: _____

Paternal Great Grandmother

Name: _____
Tribe: _____
Roll# _____
Deceased: Yes /No Year:
Date of Birth: _____

Maternal Great Grandfather

Name: _____
Tribe: _____
Roll # _____
Deceased: Yes / No Year:
Date of Birth: _____

Maternal Great Grandmother

Name: _____
Tribe_____
Roll# _____
Deceased: Yes / No Year:
Date of Birth: _____

Central Valley Indian Health, Inc.

Purchased Referred Care Patients Notification of Pharmacy Benefits Letter.

Central Valley Indian Health has identified you as being Purchased Referred CARE Eligible (This status may be pending final review by the Eligibility Committee). As a PRC eligible patient you are eligible for pharmacy benefits. Pharmacy benefits are only good at contracted pharmacies which include the following:

CVS Pharmacy
29412 Auberry Road
Prather, CA 93651
PH: 559-855-4220

Raley's Oakhurst
40041 Highway 49
Oakhurst, CA 93644
PH: 559-683-8300

Blue Cross Medi –Cal
Costco, Raleys, Rite Aid,
Safeway, Target, Vons,
Walmart, Save Mart

The Medicine Shoppe
195 W. Shaw, Suite 101-A
Clovis, CA 93612
PH: 559-297-0251

Save-Mart Supermarket
105 W. Hanford/Armona Road
Lemoore, CA 93245
PH: 559-924-9593

**Blue Cross Medi-Cal patients may Raley's (Oakhurst) or Save-Mart (Lemoore). Blue Cross Medi-Cal is not accepted at CVS or The Medicine Shoppe. Patients may use one of the other listed Pharmacies above for Blue Cross Medi- Cal.*

As a PRC Eligible patient, you are obligated to notify CVIH staff, contracted pharmacies and specialty providers of any Medi- Cal, Medicare Part D, private insurance or other insurance coverage that you may have. Your pharmacy benefits at CVIH will work with whichever pharmacy benefits your insurance may offer. If you have any questions about your pharmacy benefits, please contact PRC at 559-299-3262 Ext. 1812 or Ext. 1811 or Ext. 1810.

Patients Name: _____D.O. B_____

Patient Insurance (Circle One) Yes / No If yes, list insurance_____

Pharmacy ID# CVIH_____ Effective Date _____

I certify that the information listed above is true and correct. I agree to notify CVIH in the event that there is any change to my insurance coverage. I also give CVIH permission to notify CVIH Contract pharmacies of Pharmacy ID# and insurance information. I plan to use the _____ pharmacy.

_____ _____

Patient Signature Date CVIH Staff Signature Date

CC: Eligibility File Pharmacy

Central Valley Indian Health, Inc.

Important Notice

To: Medicare Beneficiaries for Purchased Referred Care Services

Subject: Your Prescriptions Drug Plan (PDP) coverage under Medicare Part D and the Annual Credible Coverage Letter (42 CFR 423.56)

IHS has obtained authorization from CMS to discontinue the annual Creditable Coverage Notification letter sent to you each year. IHS is considered a Creditable Coverage provider and you as an IHS beneficiary are considered to have creditable coverage. What this means is that if you should decide to enroll in Medicare Part D, you may enroll in a Medicare Prescription Drug Plan (PDP) *without incurring a late enrollment penalty*. If you enroll in a PDP, you will be able to obtain a creditable coverage letter from your local IHS service unit. This letter can be used to verify that you are an IHS beneficiary and that you have a creditable prescription drug coverage.

For additional information, you can also go to the Patient Service Representative at Central Valley Indian Health or contact out office for further information by calling 559-299-3236 Ext. 1811. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227) or go to their website at www.medicare.gov TTY users should call 1-877-486-2048.

Central Valley Indian Health

Purchased Referred Care Referral Guide

Before any referral can be made the Patient Services Representative must determine if you are eligible for any other coverage, including but not limited to, Medicare, Medi – Cal, or private insurance, etc. If you have any questions, please contact the Patient Service Representative ay (559) 299-3262 Ext. 1811.

When a patient is referred to an outside specialist by a CVIH Medical or Dental provider, for covered services, if you are referred to a specialist and that specialist refers you to another specialist you must notify the CVIH Staff (Medical or Dental).

- Eye Exam (For contacts or glasses/ not both)
- Reimbursement (for contacts or glasses/ not both) up to $100.00 Annually

Any charges over these amounts will be the patient's responsibility.

Please be aware that some specialist has a charge for missed appointments that have not been cancelled or rescheduled. CVIH will not cover this charge – you will be responsible. After three no– show/ late cancellations or reschedules. CVIH will not cover this charge – you will be responsible. After three no–shows/late cancellations the provider my disengage the patient from any further services at their facility. Emergency, in patient services are not covered.

_____	_____
Patient	Date
_____	_____
Patient Representative (Parent/ Guardian)	Date
_____	_____
CVIH Representative	Date