



## **PATIENT ELIGIBILITY PACKET**



## 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](http://www.cvih.org).

Thank you!

CLOVIS  MED  DEN  
 PRATHER  MED  DEN  
 NORTH FORK  MED  DEN  
 TACHI  MED  DEN

**CENTRAL VALLEY INDIAN HEALTH  
PATIENT REGISTRATION**

DO YOU HAVE ANY SPEICAL NEEDS?  
 SIGHT  HEARING  
 AMBULATORY  
 SPEECH

PATIENT INFORMATION		PATIENT NO: _____
LEGAL LAST NAME:	FIRST:	MIDDLE:
DATE OF BIRTH:	CITY OF BIRTH:	STATE OF BIRTH:
SEX:	SOCIAL SECURITY NUMBER:	
MARITAL STATUS: <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCE <input type="checkbox"/> WIDOWED <input type="checkbox"/> 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: <input type="checkbox"/> YES <input type="checkbox"/> NO	WHERE: _____	
EMPLOYMENT STATUS: <input type="checkbox"/> UNEMPLOYED <input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME <input type="checkbox"/> SELF EMPLOYED <input type="checkbox"/> 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: <input type="checkbox"/> WHITE <input type="checkbox"/> ASIAN <input type="checkbox"/> BLACK <input type="checkbox"/> FILIPINO <input type="checkbox"/> HISPANIC/LATINO <input type="checkbox"/> PACIFIC ISLANDER <input type="checkbox"/> 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)

\_\_\_ CLOVIS \_\_\_ MED \_\_\_ DEN  
 \_\_\_ PRATHER \_\_\_ MED \_\_\_ DEN  
 \_\_\_ NORTH FORK \_\_\_ MED \_\_\_ DEN  
 \_\_\_ TACHI \_\_\_ MED \_\_\_ DEN

**CENTRAL VALLEY INDIAN HEALTH  
 PATIENT REGISTRATION**

DO YOU HAVE ANY SPEICAL NEEDS?  
 \_\_\_ SIGHT \_\_\_ HEARING  
 \_\_\_ AMBULATORY  
 \_\_\_ SPEECH

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 MEDI CARE? NO	YES	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:		

CLOVIS  MED  DEN  
 PRATHER  MED  DEN  
 NORTH FORK  MED  DEN  
 TACHI  MED  DEN

**CENTRAL VALLEY INDIAN HEALTH  
PATIENT REGISTRATION**

DO YOU HAVE ANY SPEICAL NEEDS?  
 SIGHT  HEARING  
 AMBULATORY  
 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/State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

This information is necessary pursuant 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: \_\_\_\_\_



**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  
CC: Eligibility File Pharmacy

\_\_\_\_\_  
CVIH Staff Signature                      Date





## 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 our 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](http://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 may 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