



**CENTRAL VALLEY INDIAN HEALTH, INC.
PATIENT ELIGIBILITY PACKET**



PATIENT REGISTRATION FORM

Legal Last Name: _____ First Name: _____ Middle: _____

Date of Birth: _____ City of Birth: _____ State of Birth: _____

Social Security Number: _____ Sex: Male Female Other _____

Marital Status: Single Married Divorced Widowed Separated

Home Address: _____ City: _____ State: _____ Zip code: _____

Mailing Address: _____ City: _____ State: _____ Zip code: _____

Home Phone Number: _____ Cell Phone Number: _____

Email Address: _____ Do you accept text messages: Yes No

Date moved to present community: _____ Internet Access: Yes No

Employment Status: Full-Time Part-Time Self-Employed Unemployed Retired Other: _____

Race: Indian/Alaskan Native White Asian Black Hispanic Other: _____

Ethnicity: Hispanic Non-Hispanic Other: _____ Language: English Spanish Other: _____

Do you have any special needs: Sight Hearing Ambulatory Speech Other: _____

Preferred Pharmacy Name and Location: _____

Responsible Party: Self Spouse Parent/Guardian Other: _____

Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Emergency Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

Next of Kin Contact Name: _____ Phone Number: _____

Address: _____ Relationship: _____

PARENTAL INFORMATION *(Complete only if application is for a child/minor)*

Father's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Employer Name: _____

Mother's Name: _____ Date of Birth: _____ SSN: _____

Address: _____ Phone Number: _____

Employer Name: _____

ELIGIBILITY - RELIGION - TRIBAL INFORMATION

Religious Preference: _____

Tribe of Membership: _____ Indian Blood Quantum: _____

Tribe Address: _____ City: _____ State: _____ Zip code: _____

Name of Reservation: _____

Other Tribe Information: _____

Father's Name: _____

Father's City & State of Birth: _____ Tribe: _____

Mother's Name: _____ Mother's Maiden Name: _____

Mother's City & State of Birth: _____ Tribe: _____



INSURANCE INFORMATION

Type of Insurance: Medi-Cal Medicare Private Insurance/PPO Other: _____
Insurance Name: _____
Policy Number: _____ Subscriber Number: _____
Date of Birth: _____ Social Security Number: _____

Secondary Insurance

Type of Insurance: Medi-Cal Medicare Private Insurance/PPO Other: _____
Insurance Name: _____
Policy Number: _____ Subscriber Number: _____
Date of Birth: _____ Social Security Number: _____

VETERAN INFORMATION

Are you a Veteran: Yes No Do you have a valid VA Card: Yes No
Service Branch (Last): _____ Service Entry Date (Last): _____
Service Separation Date (Last): _____ Vietnam Service Indicated: Yes No
Service Connected: Yes No Claim Number: _____
Description of VA Disability: _____

ASSIGNMENT AND RELEASE

AUTHORIZATION 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 hereby 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.

Patient/Guardian Signature: _____ **Date:** _____

Parent/Guardian Name: _____

*****PLEASE ATTACH ALL DOCUMENTS REQUIRED BY CVIH IN ORDER TO VERIFY ELIGIBILITY*****

******* OFFICE USE ONLY *******

REGISTRATION COMPLETE: YES NO TRIBAL VERIFICATION RECEIVED: YES NO
ID CARD RECEIVED: YES NO TYPE OF VERIFICATION: _____
INSURANCE CARD RECEIVED: YES NO
FEE SCHEDULE: CONTRACT CARE DIRECT CARE CVIH STAFF CVIH STAFF FAMILY NON-INDIAN
 PRIVATE PAY SLIDING FEE VETERAN PENDING VERIFICATION
SERVICE ELIGIBILITY: CONTRACT CARE DIRECT CARE INELIGIBLE PENDING
TRIBE NAME: _____ BLOOD QUANTUM: _____
BENEFICIARY CLASSIFICATION: INDIAN/ALASKAN NATIVE NON-INDIAN EMERGENCY NON-INDIAN ELECTIVE
 NON-INDIAN DEPENDENT NON-INDIAN FEE CHARGED
COMMUNITY OF RESIDENCE: _____
CVIH SITE: CLOVIS MEDICAL CLOVIS DENTAL TACHI MEDICAL TACHI DENTAL NORTH FORK
 PRATHER MEDICAL PRATHER DENTAL BULLARD BHS
VERIFIED AND ENTERED BY: _____ DATE: _____
MISSING DOCUMENTS/NOTES: _____

DOCUMENTS REQUIRED BY CVIH IN ORDER TO VERIFY ELIGIBILITY

Patients must comply with alternate resource requirements within 30 days.

ALL PATIENTS

- CVIH Patient Registration Form
- Photo ID Card (all applicants 18 yrs. +)
- Social Security Number
- Insurance Card(s)
 - Copy of private insurance card
 - Medi-Cal card
 - Medicare card
- Alternate Resource Determination Form

DIRECT CARE PATIENTS

- All the above documents, including those listed below
- County Certificate of Live Birth (only if you are applying for someone other than yourself)
 - Need all CLB's up to the documented Native American
- Family Tree (only if you are applying for someone other than yourself)
 - Up to the documented Native American
- Bureau of Indian Affairs (BIA) Letter or Tribal Documents
 - Tribal Card/Letter

PURCHASED REFERRED CARE PATIENTS

*****MUST LIVE IN THE FRESNO, MADERA OR KINGS COUNTY FOR PURCHASED REFERRED CARE SERVICES*****

- All the above documents, including those listed below
- Purchased Referred Care Notification of Pharmacy Benefits Form
- CVIH Purchased Referred Care Referral Guide Form

For additional information, please visit our website at: www.cvih.org



PATIENT REQUIREMENT FOR ALTERNATE RESOURCE DETERMINATION

Date: _____

Patient Name: _____ Date of Birth: _____

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 answer all items below.

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/Kaiser insurance? YES NO

- If you answered YES to any of the above question, please provide a copy to our office
- If you answered NO to all of the above questions, you will need to be screened by a Patient Service Representative for alternate resources. Please call 299-3262 Ext. 1811 or 1810 for further assistance.
- You may also apply at the Social Service office in the county where you reside, online or with our Patient Services 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 a CVIH Patient Services Representative at 559-255-2578 ext. 1812 or 1810. You have 30 days to complete the necessary information and return this to the Eligibility Office. If required document(s) are not submitted and there is no request for assistance, a denial letter will be issued*****

FAMILY TREE

Patient Name: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell: _____

Are you/patient adopted: YES NO Are you/patient parents adopted: YES NO If yes, list biological parents: _____

<p>Father</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Great Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Great Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>
<p>Mother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Great Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Paternal Great Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>
<p>Mother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Great Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Great Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>
<p>Mother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Great Grandfather</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>	<p>Maternal Great Grandmother</p> <p>Name: _____ Tribe Name: _____ Roll #: _____ Date of Birth: _____ Deceased: Yes Year: _____ / No</p>



PURCHASED REFERRED CARE PATIENT NOTIFICATION OF PHARMACY BENEFITS

Central Valley Indian Health, Inc. has identified you as being Purchased Referred Care (PRC) eligible (your status may still 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 below:

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

THE MEDICINE SHOPPE
 195 W. Shaw, Suite 101-A
 Clovis, CA 93612
 H: 559-297-0251

BLUE CROSS MEDI –CAL
 Costco, Raley’s, Rite Aid,
 Safeway, Target, Vons
 Walmart & Save Mart

RALEY’S OAKHURST
 40041 Highway 49
 Oakhurst, CA 93644
 PH: 559-683-8300

SAVE-MART SUPERMARKET
 105 W. Hanford Armona Road
 Lemoore, CA 93245
 PH: 559-924-9593

****Blue Cross Medi-Cal is NOT accepted at CVS or The Medicine Shoppe. Patients may use one of the other listed Pharmacies above****

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 a PRC Representative at 559-299-3262 ext. 1812 or ext. 1811 or ext. 1810.

Patient Name: _____ Date of Birth: _____

Do you have insurance (Circle One): Yes / No If yes, list insurance: _____

I plan to use the _____ pharmacy.

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.

 Patient Signature Date

 CVIH Representative Signature Date

 Parent/Guardian Signature Date

 Parent/Guardian Name

Pharmacy ID# CVIH _____

Effective Date _____

CC: Eligibility File Pharmacy



IMPORTANT NOTICE FOR 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. 1810 or 1811. You may also contact Medicare at 1-800-MEDICARE (1-800-633-4227) or go to visit the 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 is made, a CVIH 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.

When a patient is referred to an outside specialist by a CVIH medical or dental provider for covered services, and then again referred out to another specialist by that specialist, you must contact your CVIH medical or dental provider or referral representative.

For optical, covered services are limited to:

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

Any charges or fees over these amounts are the patient's responsibility.

Each specialist has their own appointment policies and procedures. Some specialists may charge fees for no-show, missed, cancelled/late cancelled or rescheduled appointments. CVIH will not cover these charges - you are responsible for these fees. After three no-show or late appointment cancellations, specialists may also disengage you from any further services at their facility. Emergency in-patient services are not covered. If you have any questions, please contact a Patient Service Representative at (559) 299-3262 ext. 1810 or 1811.

Patient Name: _____

Date of Birth: _____

Patient Signature

Date

Patient Parent/ Guardian Signature

Date

Parent/Guardian Name: _____

CVIH Representative Signature

Date