HRN#_____

PATIENT REGISTRATION APPLICATION REQUIREMENTS CHECKLIST

Patient Name:_____
Last, First, Middle

Forms Required:

- ☐ Application for Health Care Services
- ☐ Information Sheet – Payor of Last Resort
- ☐ Statement of Understanding – Direct Care Services
- ☐ Statement of Understanding – Purchase & Referred Care (formerly Contract Health Services)
- ☐ Notice of Privacy Practices Acknowledgement and Consent
- ☐ Authorization for Use or Disclosure of Protected Health Information (HIPPA)
- ☐ Indian Health Services Release of Information
- ☐ Pequot Health Care Release of Information

Documentation Required:

- ☐ Tribal Affiliation/Enrollment Verification
- ☐ Marriage Certificate (Tribal Spouses Only)
- ☐ Proof of Residency
- ☐ Social Security Card
- ☐ Insurance Card(s)
- ☐ Birth Certificate
- ☐ Photo ID

Additional Documentation Required For:

Adopted, Foster, Step Children

- ☐ CPS Verification
- ☐ Legal/Court Documentation
- ☐ Marriage Certificate

Non-Indian Pregnant w/ Eligible Indian's Child

- ☐ Notarized Paternity Statement signed by eligible Indian
- ☐ Order of Court of Competent Jurisdiction

HRN:_____

MASHANTUCKET PEQUOT TRIBAL NATION
TRIBAL HEALTH SERVICES
75 Route 2, PO Box 3260
Mashantucket CT 06339-3260

Today's Date: _____

Last Name: _____ First Name:_____ Middle Initial:_____
Address: _____
City:_____ State:_____ Zip:_____
Home Phone: (___) _____ Social Security#:_____
Email Address: _____ Cell Phone#:_____
Date of Birth: _____ Sex: M/F Marital Status: S____ M____ D____ W_____
Primary Language: ☐English ☐Spanish ☐Other_____
Employer Name: _____ Employer Phone Number: (____)_____
Employer Address: _____
Emergency Contact Name: _____ Emerg. Phone #: _____

INSURANCE INFORMATION

PLEASE PROVIDE A CURRENT COPY OF YOUR INSURANCE CARD(S)

PRIMARY INSURANCE:
Plan Name: _____ I.D. Number: _____
Policy Holder: _____ Effective Date: _____
Claim Address: _____
SECONDARY INSURANCE:
Plan Name: _____ I.D. Number: _____
Policy Holder: _____ Effective Date: _____
Claim Address: _____

Are you Hispanic or Latino?	Y☐	N☐
Are you receiving Black Lung (BL) benefits?*	Y☐	N☐
Are the services to be paid by a government program or research grant?*	Y☐	N☐
Has the Department of Veteran Affairs (DVA) authorized and agreed to pay for care?*	Y☐	N☐
Was the illness/injury due to a work related accident or condition?*	Y☐	N☐
Was the illness/injury due to an automobile accident?*	Y☐	N☐

Are you entitled to Medicare based on?
Age? Y☐ N☐ Disability? Y☐ N☐ ESRD? Y☐ N☐

If you have answered yes to any of these questions, please notify the receptionist.

_____ _____ _____
Patient (or Responsible Party if under 18 years old) Relationship Date

Please read and sign back of form

ASSIGNMENT OF INSURANCE BENEFITS:

I hereby authorize direct payment of my insurance benefits to Mashantucket Pequot Tribal Health Services for the services rendered to me or my dependents by the physician or under his/her supervision. I understand that it is my responsibility to know my insurance benefits and whether or not the services I am to receive are a covered benefit.

MEDICARE/MEDICAID/CHAMPUS

I certify that the information given by me in applying for payment under these programs is correct. I hereby direct that payment of my or my dependent's authorized benefits be made directly to Mashantucket Pequot Tribal Health Services.

RELEASE OF INFORMATION:

I certify that I have received and read a copy of the Patient Information Privacy Policy. I hereby authorize Mashantucket Pequot Tribal Health Services to release any of my or my dependent's medical or personal information that may be necessary for medical evaluation, treatment, consultation or the processing of insurance benefits.

LAB/X-RAY/DIAGNOSTIC SERVICES:

I understand that I may receive a separate bill if my medical care includes lab, x-ray or other diagnostic services. I further understand that I am financially responsible for any co-pay or balance due for these services if they are not reimbursed by my insurance for whatever reason.

Patient Signature: _____ Date: _____

Parent/Legal Guardian Signature: _____ Date: _____
(If patient under age 18)

HRN#_____

MASHANTUCKET PEQUOT TRIBAL HEALTH SERVICES

Name:_____ SSN:_____
Last, First, Middle

Marital Status: ☐M ☐S ☐D ☐W Application Completed: ☐Onsite ☐Offsite

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

Do you go by any other name (Surname):_____

Street Address:_____
P.O. Box:_____
City:_____ State:_____ Zip:_____

Mailing Address (if different from above):

Street Address:_____
P.O. Box:_____
City:_____ State:_____ Zip:_____

How long have you resided in New London County?_____
Temporarily in service area: ☐Yes ☐No If yes, length of time?_____
Home phone:_____ Alternate phone:_____
Are you: ☐Employed ☐Unemployed ☐Retired ☐Disabled ☐Student
If employed:

Name of employer:_____
Employer address:_____
Employer phone:_____
☐Full-time ☐Part-time ☐Casual ☐Seasonal ☐Temporary
Migrant worker: ☐Yes ☐No

Religious preference:_____
Ethnicity: ☐Not Hispanic or Latino ☐Hispanic or Latino ☐Unknown ☐Declined to Answer
Tribal affiliation:_____
Method of collection:_____
Degree of blood and/or roll number:_____
Primary/Preferred Language:_____ Other language spoken:_____

Father's Name:_____ City & State of Birth_____

Phone:_____ Employer:_____

Mother's Name (maiden):_____ City & State of Birth:_____

Phone:_____ Employer:_____

Names of dependent(s) in household (continue on back if more space is needed):

NAME	DOB	SSN	TRIBE	RELATIONSHIP

Emergency Contact:

Name:_____ Relationship:_____

Street Address:_____

City & State:_____ Zip:_____

Phone:_____

Next of Kin:

Name:_____ Relationship:_____

Street Address:_____

City & State:_____ Zip:_____

Phone:_____

Preferred Method of Communication: □ Phone □ U.S. Mail □ E-Mail

Do you have access to the internet: □ Yes □ No E-Mail Address:_____

Internet Access Method: □ Home □ Work □ Other:_____

Are you a Veteran: □ Yes □ No If yes, what branch?_____ C No_____

Are you covered by any other IHS/CHS program? □ Yes □ No

If yes, please provide name & address of IHS/CHS program:_____

Provider Information

Primary care provider:_____ Phone:_____

Dental care provider:_____ Phone:_____

Pharmacy:_____ Phone:_____

Health Insurance Information

Are you covered by: ☐Medicare ☐Medicaid ☐Other Health Insurance

Health Insurance (primary):_____

Address:_____

Group#:_____ ID#:_____

Name of Insured:_____ Relationship:_____

Health Insurance (secondary):_____

Address:_____

Group#:_____ ID#_____

Name of Insured:_____ Relationship:_____

To the best of my knowledge, all of the information provided is true and accurate

_____ _____

Individual/Minor Child's Name Date

_____ _____

Parent/Legal Guardian Signature Date

_____ _____

MPTN IHS Patient Registration Representative Date

For Office Use Only:

Eligibility: ☐CHS/Direct Care ☐Direct Care Only ☐Non-Eligible

Change of Eligibility: ☐Direct to CHS/Direct Care ☐CHS/Direct Care to Direct Care Only

Application completed on:_____ Application Incomplete:_____

Missing Information: ☐Tribal Affiliation ☐Proof of Residency ☐Social Security Card

☐Insurance Card ☐Birth Certificate ☐Legal Documents ☐Driver's License/State ID

Director of Tribal Health Services:_____ Date:_____

STATEMENT OF UNDERSTANDING

FOR DIRECT CARE SERVICES

The Mashantucket Pequot Tribal Health Services (MPTHS) provides Direct Care Services (DC) to I.H.S. eligible clients. Direct Care Services are those services that can be safely provided by our staff on-site at the MPTHS and/or limited medical/social services within the client' home when scheduling allows. Limited in-home medical and/or social services can only be provided to those I.H.S. clients living within New London County. **Direct Care Services are provided by scheduled appointment as well as walk-in clinic appointment.**

- To receive I.H.S. services at the MPTHS, you must meet the following requirements:
- Federally recognized Native American/Alaskan Native
- Person of Indian descent belonging to the Indian community served by the local facility program
- Person regarded as an Indian by the Indian community in which he/she lives as evidenced by tribal membership, enrollment, resident on tax exempt land or other factors within general Bureau of Indian Affairs practices
- In the case of a Non-Indian pregnant with an eligible Indian's child (paternity must be acknowledged in writing by the Indian or determined by order of a court of competent jurisdiction)
- Non-Indian member of an Indian household if medical officer in charge determines that it is necessary to control a communicable disease or in the case of a public health hazard

My signature below certifies that the Indian Health Services has explained the referral process to me and I understand that if I do not meet the requirements for Contract Health Services (CHS) all referrals for additional medical services not available at the Mashantucket Pequot Tribal Health Services are my responsibility. This includes laboratory and x-ray services.

Individual/Minor Child Name	Date
Signature of Parent/Legal Guardian	Date
Signature and Title of IHS/CHS Employee	Date

STATEMENT OF UNDERSTANDING

FOR CONTRACT HEALTH SERVICES

The Mashantucket Pequot Tribal Health Services (MPTHS) provides Contract Health Services (CHS) to I.H.S. eligible clients. Contract Health Services are those services that are provided by an outside provider other than the Tribal I.H.S. health program and receive payment assistance from the MPTHS/CHS program.

Payer of Last Resort:

CHS is the payer of last resort (residual payer). All available alternate resources including but not limited to Medicare, Medicaid, HUSKY, and the Mashantucket Pequot Benefit Plan (MPBP) must be exhausted prior to payment by the CHS program. If it is determined that the client may be eligible upon application for an alternate resource by the MPTHS or the Medical/Social Service Representative, the client must apply for that resource prior to payment by the CHS program.

Client responsibilities:

- It is the responsibility of the client to notify MPTHS 72 hours (3 days) prior to each NON-EMERGENCY APPOINTMENT.
- It is the responsibility of the client in the event of an EMERGENCY to notify the MPTHS within 72 hours (3 days) following said emergency.
- It is the responsibility of the client to ensure that all dental pre-treatment plans have been submitted to the CHS office for approval *prior* to receiving treatment.
- It is the responsibility of the client when notifying the CHS of a non-emergency appointment the reason for the appointment to ensure that the services provided fall within the current CHS medical/dental priority level.
- It is the responsibility of the client to provide the CHS program with the explanation of benefits (EOB) from their primary and secondary (if applicable) insurer.

My signature below certifies that the Indian Health Services has explained the referral process to me and I understand that if I do not follow the requirements for Contract Health Services (CHS) all referrals for additional medical services not available at the Mashantucket Pequot Tribal Health Services are my responsibility. This includes laboratory and x-ray services.

_____	_____
Individual/Minor Child Name	Date
_____	_____
Signature of Parent/Legal Guardian	Date
_____	_____
Signature and Title of IHS/CHS Employee	Date

MASHANTUCKET PEQUOT TRIBAL NATION
TRIBAL HEALTH SERVICES
75 ROUTE 2, PO BOX 3260
MASHANTUCKET CT 06339-3260
860-312-8000

PAYMENT AUTHORIZATION

I hereby authorize my medical insurance to make payment directly to Mashantucket Pequot Tribal Health Services. I hereby affirm that all payments made directly to me for services provided by Mashantucket Tribal Health Services will be forwarded to their office upon receipt. I understand I am responsible for any amounts not covered by my insurance plan. This includes co-pays, deductibles, non-covered services, as well as referred services such as lab and x-ray. A photocopy of this assignment is to be considered as valid as the original.

Patient Name	Date
Signature of Patient or Parent/Legal Guardian	Date
Signature and Title of IHS Employee	Date

MASHANTUCKET PEQUOT TRIBAL HEALTH SERVICES

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records. We will use and share your health records as required by law and in accordance with the MPTHS HIPAA Notice of Privacy Practices Policy (see attached).

You have the following rights with respect to your health records:

1. You have the right to inspect and receive a copy of your health records.
2. You have the right to correct/amend your health record.
3. You have the right to request a restriction on use and disclosure of your record.
4. You have the right to request confidential communications about your information.
5. You have the right to receive a list of whom we have given your health records to.
6. You have the right to revoke your written authorization to use/disclose health information.
7. You have the right to obtain a paper copy of IHS Notice of Privacy Practices.
8. You have the right to obtain a copy of your health record.

My signature acknowledges that I have read and understand the MPTHS HIPAA Privacy Practices and Policy and CONSENT to the use and sharing of my health records in compliance with the attached HIPAA Policy. I further acknowledge that my patient rights have been explained to me.

_____ _____

Individual/Minor Child Name Date

_____ _____

Signature of Parent/Legal Guardian Date

_____ _____

Signature and Title of IHS/CHS Employee Date

Mashantucket Pequot Tribal Health Services

PRIVACY ACT SIGNATURE FORM

I Have read the Privacy Act Notice. I have been informed that my record is or will be kept in the Health and Medical Records System at:

Mashantucket Pequot Tribal Health Services

75 Route 2

PO Box 3260

Mashantucket, CT 06338-3260

I understand that the information given by me and/or collected and stored in my health record is necessary for Indian Health Services staff or Indian Health Services contractors, to provide services for my health and well-being. Furthermore, I have been informed that my health record or any portion of my health record shall not be disclosed to another agency or person, unless specified as routine use (listed on the "Why We Ask Questions" notice), without my signed consent.

_____ _____

(Signature of Individual) (Date)

_____ _____

(Signature of Guardian for Minor) (Date)

_____ _____

(Signature and Title of HIS Employee) (Date)

THIS FORM IS NOT A PREREQUISITE TO PROVIDING SERVICES

Pequot Health Care
HIPAA Officer
1 Annie George Drive
Mashantucket, CT 06338
Phone: 888-779-6872
Local: 860-396-6489

PEQUOT
HEALTH CARE

PEQUOT PHARMACEUTICAL NETWORK
1-800-342-5779

PEQUOT PLUS
Health Benefit Services
1-888-779-6872

Due to the confidential nature of your protected health information (PHI) maintained by Pequot Health Care (Pequot Pharmaceutical Network (PRxN) and Pequot Plus Health Benefits Services) and applicable Health Insurance Portability and Accountability Act (HIPAA) regulations, all requests for any PHI must be submitted using this form to the HIPAA Officer, Pequot Health Care.

Patient Name: _____ Date of Birth: _____

Primary Cardholders SS#: _____

Card Member ID# (alternate ID): _____

I, (print name) _____, hereby authorize Pequot Health Care to release my pharmacy / medical health records information to:

Name of Recipient: _____

Address: _____
(where request is to be mailed) _____

Date request submitted: _____ Date required: _____
(allow a minimum 10 business days*)

The specific information requested consists of: *(Please include time period of requested information)*

Note: This description must be specific and meaningful.

The information will be used/disclosed for the following purposes:

This authorization is valid until revoked, in writing, and properly presented to the PHC HIPAA Officer.

I understand that if the person or the entity that receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time by submitting a written notice of my revocation, except to the extent that action has been taken in reliance on this authorization.

The authorization expires on: _____. If responding with a date, please allow Pequot Health Care adequate time to process this request and provide a response.

_____ _____
Signature of Patient/Client Date
or an authorized representative, parent or guardian if a minor, please specify relationship to patient/client. If a representative signs, please provide proof of authority to act on behalf of the patient.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Form Approved: OMB No. 0917-0030
Expiration Date: January 31, 2024
See OMB Statement on Reverse.

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ , hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

II. THE INFORMATION IS TO BE DISCLOSED BY:	**AND IS TO BE PROVIDED TO:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY
ADDRESS	ADDRESS
CITY/STATE	CITY/STATE

III. THE PURPOSE OR NEED FOR THIS DISCLOSURE IS:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange *(IHS/Other)* _____

IV. THE INFORMATION TO BE DISCLOSED FROM MY HEALTH RECORD: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____
☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY *(by checking this box, I am waiving any psychotherapist-patient privilege)*

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date (mm/dd/yyyy))

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE *(mm/dd/yyyy)*
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE *(mm/dd/yyyy)*

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

	NAME *(Last, First, MI)*	
	ADDRESS	
	CITY/STATE	
	DATE OF BIRTH *(mm/dd/yyyy)*	RECORD NUMBER

PSC Publishing Services (301) 443-6740 EF

Instructions for Completing IHS Form 810
AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Print legibly in all fields using dark permanent ink.
2. Section I, print your name or the name of patient whose information is to be released.
3. Section II, print the name and address of the facility releasing the information. Also, provide the name of the person, facility, and address that will receive the information.
4. Section III, state the reason why the information is needed, e.g., disability claim, continuing medical care, legal, research-related projects, etc. For an Health Information Exchange (HIE) other than IHS, please provide the name of the HIE.
5. Section IV, check the appropriate box as applicable.

   a. **Only information related to** – specify diagnosis, injury, operations, special therapies, etc.

   b. **Only the period of events from** – specify date range, e.g., Jan. 1, 2002, to Feb. 1, 2002.

   c. **Other (specify)** – e.g., Purchased Referred Care (PRC), Billing, Employee Health.

   d. **Entire Record** – complete record including, if authorized, the sensitive information (alcohol and drug abuse treatment/referral, sexually transmitted diseases, HIV/AIDS-related treatment, and mental health other than psychotherapy notes).

   e. **IN ORDER TO RELEASE SENSITIVE INFORMATION REGARDING ALCOHOL/DRUG ABUSE TREATMENT/REFERRAL, HIV/AIDS-RELATED TREATMENT, SEXUALLY TRANSMITTED DISEASES, MENTAL HEALTH (OTHER THAN PSYCHOTHERAPY NOTES), THE APPROPRIATE BOX OR BOXES *MUST* BE CHECKED BY THE PATIENT.**

   f. **Psychotherapy Notes ONLY – IN ORDER TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES, ONLY THIS BOX SHOULD BE CHECKED ON THIS FORM. AUTHORIZATIONS FOR THE USE OR DISCLOSURE OF OTHER HEALTH RECORD INFORMATION MAY NOT BE MADE IN CONJUNCTION WITH AUTHORIZATIONS PERTAINING TO PSYCHOTHERAPY NOTES.**

      IF THIS BOX IS CHECKED WITH OTHER BOXES, ANOTHER AUTHORIZATION WILL BE REQUIRED TO AUTHORIZE THE USE OR DISCLOSURE OF PSYCHOTHERAPY NOTES ONLY.

      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used by the provider for future sessions. These notes are often kept separate to limit access because they contain sensitive information relevant to no one other than the treating provider.

   g. When you opt-in to share information through the HIE, an expiration date must be entered.

6. Section V, if a different expiration date is desired, specify a new date. For HIE, a date 5 years in the future is recommended in order to provide health information for continuity of care.
7. Section V, Please sign (or mark) and date.
8. A copy of the completed IHS-810 form will be given to you.

OMB STATEMENT

Public reporting burden for this collection of information is estimated to average 10 minutes per response including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: Indian Health Service, Office of Management Services, Division of Regulatory Affairs, Mail Stop 09E70, 5600 Fishers Lane, Rockville, MD 20857, RE: OMB No. 0917-0030. Please DO NOT SEND this form to this address.

PRIVACY ACT NOTIFICATION STATEMENT

(To be given to persons provided health care by the Indian Health Service (IHS) or by contractors receiving funds from the IHS)

When Federal Employees or Federal Contractors keep records about people, they must give the people information about the records they are keeping. The Privacy Act of 1974 (Public Law 93.579) requires that the following be done:

1. You have the right to know what records about you are collected, stored, used or given out by the Federal agency or contractor and why. The page titled: "Why We Ask Questions" which comes before this notice, describes this.

More information about the health and medical information IHS employees of IHS contract employees keep about you, is found in the IHS Health and Medical Records System Notice, 09-17-0019. You can get a copy of this notice by asking someone in the IHS or IHS contractor's Medical Records Office.

2. You have the right to authorize IHS employees or IHS contract employees to send out information contained in a record about you for a purpose other than the original purpose(s) for which it was collected. Should you wish to do this, you will be asked to complete and/or sign a form titled; "Authorization For Release of Information", Form No. IHS-810.

In order to give out a copy of your record (or information contained in your record) for a purpose not covered by the "Why We Ask Questions" notice or the Systems Notice 09-17-0019, you must give your permission in writing.

If you believe your record is being used improperly, contact someone in the medical records department of the IHS facility or the IHS contractor's facility where your record is stored and inform them of your objection. You should receive a written reply to your comment within two weeks. If for some reason you do not receive a response within two weeks, contact the Service Unit Director for a response to your inquiry.

3. You have the right to see the original record or a copy of it, to have a copy made of all or any part of it and to ask for correction of information you believe is incorrect. Copies are made at the expense of IHS. Someone in the medical records department where your records are kept, will assist you with these procedures. A medically trained individual will first have to examine your record to see if it is in order before this is done. This process generally takes two weeks.

4. If you have questions about what is written in your record, you may ask the doctor to explain the entry to you. If you do not agree with an entry in the medical record, you may write to the Service Unit Director, state what you disagree with and why, and give proper identification (name, address, date of birth and signature). This statement will be made a permanent part of your record. You should receive a reply to your inquiry within two weeks.

5. IHS employees or IHS contract employees, are to ensure that the information stored in each record is (1) collected for a necessary and lawful purpose, (2) current and correct, and (3) safeguarded against misuse.

This is very important to IHS staff. Notify someone in the IHS or contractor's medical records office, if you think one of the above requirements is not being done. You should receive a written reply within two weeks. If for some reason you do not receive a response within two weeks, contact the Service Unit Director for a response to your inquiry.

PAYOR OF LAST RESORT

IHS is the payor of last resort of persons defined as eligible for CHS under the Code of Federal Regulations - 42 CFR 36.61, notwithstanding any State or local law or regulations to the contrary.

A. Accordingly, HIS will not be responsible for or authorize payment for CHS to the extent that:

1. The Indian is eligible for alternate resources, defined in paragraph (c), or for them, or
2. The Indian would be eligible for alternate resources if he or she were to apply for them, or
3. The Indian would be eligible for alternate resources under State or local law or regulation for the Indian's eligibility for CHS or other health services from IHS or IHS programs.

B. Upon application by an Indian patient for CHS the CHS Offices must:

1. Determine, upon reasonable inquiry, whether the patient is potentially eligible for alternate resources.
2. Advise the patient of the need to apply for alternate resources.
3. Assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

FAILURE TO FOLLOW ALTERNATE RESOURCE PROCEDURES

There are two instances when CHS will not pay the provider for medical bills incurred by a CHS eligible Indian patient:

1. When the patient willfully or intentionally fails to apply or fails to complete an alternate resource applications.

2. IHS will not pay the provider when the provider fails to follow alternate resource procedures, such as not notifying the program within its time constraints. IHS's trust responsibilities include requiring the providers to maximize the availability of alternate resources. Thus, if the provider is not able to receive payment from an alternate resource program because of the provider's failure to follow proper procedures, IHS will not be responsible for the medical bill, even if the Indian patient is otherwise CHS eligible.

The use of alternate resources is mandated in the Code of Federal Regulations - 42 CFR 36.23 (a).

a. An individual is required to apply for alternate resources if there is reasonable indication that the individual may be eligible for the alternate resources.
b. Refusal to apply for alternate resources when there is a reasonable possibility that one exists; or refusal to utilize an alternate resource, requires denial of eligibility for CHS.
c. An individual is not required to expend personal resource for health services to meet alternate resource eligibility or to sell valuables or property to become eligible for alternate resources.

Examples of alternate resources are those resources including IHS/tribal facilities that are available and accessible to an individual. Alternate resources would include, but not be limited to, Medicare, Medicaid, vocational rehabilitation, Veteran Administration, Crippled Children's programs, private insurance, and State programs.

OTHER ALTERNATE RESOURCE INFORMATION

1. Students whose grant includes funds for health services shall be required to use the grant funds to purchase available student health insurance.

2. When an alternate resource is identified that will require the IHS/tribal program to pay a portion of the medical care costs, the appropriate IHS form will be processed immediately to obligate the funds for the estimated balance, after the alternate resource payment. Payment will not be processed unless and until the provider has billed and received payment from the alternate resource. It is necessary to require either an Explanation of Benefits (EOB) or, in cases of denial from the alternate resource, a copy of the denial notice for the record.

DIRECT CARE SERVICES

A wide variety of services are offered through the Tribal Health Program. These services can be offered through direct care and contract health services. Direct Care Services are those services offered at the Health department at no cost to the client. All federally recognized Indians are eligible for these services to the extent that funding is available and scheduling allows.

Medical Services

Family Practice
Annual Physicals
School Physicals
Sports Physicals
Routine Gynecology
(Pap Smears, Internal Exams)
Breast Exams
Small Growth Removal
Immunizations
Referrals for Diagnostic Services
Referrals for Specialty Services

Community Health Nursing

Health Histories and Assessments
Well Child Care
Monitoring Screening for Specific Conditions
Health Education
Counseling and Advisory Services
Home Care Services
Crisis Intervention
AIDS information, Referral and Counseling
Referrals to Physicians, Dentists, Optometrists
Case Management
Communicable Disease Screening and Follow-up

Community Outreach

Note: Not eligible if patient lives outside CHSDA

Home Visits
Limited Screening
Patient Education and General Assistance
Advocacy
Referral to Community Health Nursing
Patient Transportation

Behavioral Health

Assessments and Evaluations
Prevention Education
Crisis Intervention
Counseling
1. *Individual*
2. *Small group*
3. *Family*

Nutrition Services

Podiatry Services

Community Injury Control

Note: Not eligible if patient lives outside CHSDA

Community Bases Education
Injury Surveillance
Youth Safety Projects

CONTRACT HEALTH SERVICES

When the Mashantucket Pequot Health department is unable to provide certain services at the clinic, the Health department will refer the patient to a contract provider for treatment. The monies used to pay for these services/referrals are known as Contract Health Services (CHS) and are provided through the Mashantucket Pequot Health Department's contract with IHS. Payment is made on medical claims provided the following conditions are met:

(1) Eligibility (2) Availability of alternate resources (3) Notification requirements (4) Authorization of payment (5) Health services priorities.

ELIGIBILITY FOR CONTRACT HEALTH SERVICES

1. Federally Recognized Native American

2. Reside on the MPTN Reservation or in the Contract Health Service Delivery Area (CHSDA), New London County.

3. Members of the Mashantucket Pequot Tribe

4. Maintain social and economic ties to MPTN

    a. Legal Marriage to MPTN Member and/or
    b. Live on the Reservation; and/or
    c. Employed by the MPTN or MPGE

5. Transient

6. Full-time student and up to six months after leaving school.

    a. If continuing to live outside CHSDA, eligible for CHS up to 90 days after leaving school
    b. Students living outside the CHSDA must supply the CHS office with proof of college or boarding school enrollment, i.e. course schedule

7. Indian foster child (living on the Mashantucket Reservation at the time the child is placed in foster care)

8. Non-Indian Spouse/Significant Other pregnant with an eligible Indian child. Coverage of services will be for the duration of the pregnancy through six weeks post-partum.

9. Non-Indian members of a Native American Household, if the Medical Director determines it is necessary to control acute infectious disease

10. Dependent children (through the age of 18) of a federally recognized Native American who meet the social/economic criteria.

Can CHS pay for your referral medical care? Find out in 3 stages.

Individual Qualifications

Stage 1
You are eligible if:

a) You are a member or descendent of a Federally recognized Tribe or have close ties acknowledged by your Tribe*

and

b) You live on the reservation or, if you live outside the reservation, you live in a county of the CHSDA for your Tribe*

Each Contract Health Service Delivery Area (CHSDA) covers a single Tribe or a few Tribes local to the area. You are ineligible for CHS elsewhere.*

and

c) You get prior approval for each case of needed medical service or give notice within 72 hours in emergency cases (30 days for elders & disabled)

Yes for all

No for the above

Application is denied.

* *There are a few narrowly defined exceptions. Ask CHS staff for more specifics about individual eligibility, CHSDA, or prior notice.*

Relative Medical Priorities

Stage 2
Payment may be approved if:

a) The health care service that you need is medically necessary

– *as indicated by medical documentation provided*

and

b) The service is not available at an accessible IHS or Tribal facility

and

c) The facility's CHS committee determines that your case is within the current medical priorities of the facility

Unfortunately, CHS funds often are not sufficient to pay for all needed services. When this happens, the committee considers each individual's medical condition to rank cases in relative medical priority. Cases with imminent threats to life, limb, or senses are ranked highest in priority. **

and

d) CHS funds available are sufficient to pay for the service to be authorized

Yes for all

No for the above

Application is deferred.

** *Ask CHS staff for more specifics. Sometimes deferred lower priority cases may be reconsidered later if funding permits.*

Coordination and Payment

Stage 3
Approval, Billing, Payment

a) You must apply for any alternate resources for which you may be eligible
– *Medicare, Medicaid, insurance, etc.*

then

b) A CHS purchase order is issued to a provider authorizing payment for services

then

c) IHS or Tribal staff and the authorized provider coordinate your medical care

then

d) The authorized provider bills and collects from your alternate resources

then

e) The authorized provider bills any unpaid balance to CHS for payment
– *because CHS is payer of last resort, it pays only for costs not paid by your alternate resources*

Steps are completed in order

Provider is paid.

Specific services authorized within relative medical priorities may vary from time-to-time in response to changing supply and demand, especially to stretch diminished funds over the remainder of the fiscal year.

Generally applicable Contract Health Services (CHS) rules and procedures are shown. Some nuances and exceptions are omitted. Talk to CHS staff if you have questions.

DENTAL SERVICES

Dental services are covered by the CHS Department for all clients eligible for the program; however, the patient must use their primary insurance before the CHS program can provide payment assistance. All dental services must be preauthorized. An example of each dental service priority is listed below.

DENTAL SERVICE PRIORITIES

LEVEL I EMERGENCY DENTAL SERVICES

- Extractions as necessary
- Temporary fillings as necessary
- Pulpotomy or pulpectomy as necessary
- Antibiotics and analgesics as necessary

LEVEL II PREVENTIVE DENTAL SERVICES

- Teeth cleaning and oral hygiene instruction
- Topical fluoride application
- Topical application of sealants

LEVEL III SECONDARY DENTAL SERVICES (BASIC DIAGNOSTIC AND RESTORATIVE SERVICES)

- Examination and necessary radiographs
- Routine restorations (amalgams, composites, preformed crowns for primary teeth)
- Space maintainers for primary and mixed dentition patients
- Limited periodontal treatment (scaling and root planning)
- Endodontics (root canals) for anterior teeth

LEVEL IV LIMITED REHABILITATION DENTAL SERVICES

- Large, complex restorations requiring more than three tooth surfaces to be restored
- Cast crowns for endodontically treated teeth
- Endodontics (root canals) on bicuspid teeth
- Limited orthodontic treatment (children/adolescents)

LEVEL V REHABILITATION SERVICES

- Removable full or partial dentures
- Periodontic surgery
- Endodontics on first molar teeth
- Fixed bridge work
- Comprehensive orthodontic treatment (children/adolescents)

LEVEL VI COMPLEX REHABILITATION DENTAL SERVICES

- Periodontal surgery with osseous or soft tissue grafts
- Comprehensive orthodontics
- Maxilla-facial prosthetics

Services in the higher levels of care IV, V, and VI will be provided on a limited basis.

All dental services with a priority level of III or higher must be pre-certified with the Mashantucket Pequot Health benefit Plan, if the provider is seeking reimbursement for the co-payments from Tribal Health Services.

U.S. DEPARATMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE

WHY WE ASK QUESTIONS

Privacy Act Notification Statement of the Indian Health Service

Benefits

Reasons why Indian Health Service (IHS) and contract health service providers need to collect information from and about you (name, date of birth, mailing address and health information):

- To find out how you feel or what you think is wrong:
- To find out if a member of your family has a condition that could affect your health;
- To locate your medical record among all the others
- To reach you and your family (for follow-up care, or to mail medical test results or future appointments to you) to maintain your health;
- To determine your health condition and the kind of care that is right for you.

It is not necessary to answer these questions to receive medical care. However, if you give complete and correct information to the best of your ability then IHS and contract health service staff will be better able to decide what the proper care is that you need.

Uses

IHS and contract health service personnel will not reveal to anyone what is in your medical record without your written permission, except to;

- State, local or other authorized groups to provide health service to you or to reimburse contractors for the services provided to you;
- Federally approved organizations that evaluate the health care you receive;
- Persons performing health related research where IHS is assured the research will help Native American people and the information will be adequately protected;
- State or local governmental agencies which by law require the information for the purposes of law enforcement, birth and death reporting and communicable disease control;
- Local schools for the purpose of providing health care to the children they teach;
- Organizations (Medicare/Medicaid, insurance companies) for them to reimburse IHS and contract health service providers for services provided to you;
- Agencies acting on behalf of IHS to collect reimbursable payments or to make payments on behalf of the Indian Health Service.

Eligibility

Other information is required if we are to determine:

- Your eligbility to receive health care from the Indian Health Service or contract health service providers (evidence of Indian descent and your residence);
- Your eligibility to have other agencies such as Medicare, Medicaid or private insurance companies pay IHS or contractors for part or all of your health care expenses;
- Your eligibility to receive health care from other organizations (such as the Veterans' Administration).

These requirements are contained in 42 CFR Section 36.12 and 42 CFR Section 36.23. These regulations say that IHS is to obtain information on possible use of other health resources which may be used to provide you with health care. This information is to be obtained before health care is provided to you directly by IHS or by contract health providers.

Authority

Records of health care provided to you are maintained by IHS under the following laws:

- Public Health Service Act, Section 321;
- Indian Self-Determination and Education Assistance Act;
- Snyder Act;
- Indian Health Care Improvement Act;
- Construction of Community Hospitals Act;
- Indian Health Service Transfer Act.

IHS employees are required to keep a list of people to whom they release information from your medical record. You have a right to see that list. The list must show what was released, to whom (name and address), for what purpose and the date of release. You may speak with a person at the outpatient or admitting desk to find out how to do this.

The information you provide will be maintained in Health and Medical Records, Systems, HHS/PHS/IHS, (System Number 09-17-0019).

Thank You For Your Help!