Sacred Circle Healthcare
Health Division of CTGR

Purchased/Referred Care Registration Application

OFFICE USE ONLY
Patient Eligibility Status:

Direct / Tribal: ___
Direct / Other Indian: ___
Direct / Tribal Descendant: ___
Direct / Other Descendant: ___

Official Signature:

Chart #: _____

Tribe:_____
_____
_____

Tribal Quantum: _____

_____DATE: _____

A. PATIENT INFORMATION

Patient Legal Name _____
Last First Middle

For Patients Under 18 – Name of Parent/Legal Guardian: _____
Last First Middle

Relationship to Patient: _____

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

Social Security Number _____-_____-_____ Sex: ☐ Male ☐ Female ☐ Other: _____

Marital Status (Check One): ☐ Single ☐ Married ☐ Divorced ☐ Separated

Home Address: _____ City: _____ State: _____ Zip Code: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Are you a College Student: ☐ Yes ☐ No Full-Time Student ☐ Part-Time Student ☐

Email Address: _____ Home Phone: _____

Cell Phone: _____ Do you accept text messages: ☐ Yes ☐ No

Mother's Name Maiden: _____ Place of Birth: _____
First and Last City State

Father's Name: _____ Place of Birth: _____
First and Last City State

Employer: _____ ☐ Full-Time ☐ Part-Time ☐ Self-Employed ☐ Unemployed ☐ Retired

Member of a Federally Recognized Tribe: ☐ Yes ☐ No Tribe: _____

Tribal Enrollment #: _____ Tribal Blood Quantum: _____

PLEASE TURN OVER AND COMPLETE THE BACK

B. Insurance Information

Medicaid:

Have you applied for Medicaid recently? ☐ Yes ☐ No Are you eligible for Medicaid? ☐ Yes ☐ No

Date of Eligibility: _____ OR Date of Denial: _____

Recipient ID Number (Case Number): _____

Medicare:

Check all that apply: ☐ Part A ☐ Part B

Medicare Number: _____ Suffix: _____ Effective Date: _____

Insurance: ☐ Medical ☐ Dental ☐ Vision ☐ Prescriptions

Primary Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____
First and Last

Policy Holder Address: _____
Street City State Zip

Secondary Insurance Name: _____ Policy #: _____ Group #: _____

Policy Holder: _____ Policy Holder DOB: _____
First and Last

Policy Holder Address: _____
Street City State Zip

C. IN CASE OF EMERGENCY

Emergency Contact: _____ Phone Number: _____

Relationship to applicant: _____

I certify that the information that I have provided to Sacred Circle Healthcare and the Native Insurance Alliance Staff is complete and accurate. I understand that if any information should change, it is my responsibility to provide Sacred Circle Healthcare and Native Insurance Alliance Team with ALL updated information (insurance card, verification of vision, dental and health coverage, name change, address changes).
I understand that if Sacred Circle Healthcare and Native Insurance Alliance make unnecessary or improper payments on my behalf based on the information that I provided, I may be liable for such payments, and I may be ineligible for Sacred Circle Healthcare Purchased/Referred Care in the future.
I assign to Sacred Circle Healthcare and Native Insurance Alliance any medical, dental, and/or behavioral health benefits that I am entitled to under the terms of my health care coverage, in whole or in part, for the services paid for or provided by Sacred Circle Healthcare. I authorize the release of the medical information necessary to process my submitted claim. Sacred Circle Healthcare and Native Insurance Alliance shall maintain compliance with the privacy and security requirements of the Health Insurance Portability and Accountability Act (HIPAA). I agree to release my personally identifiable health information for the CTGR Sacred Circle PRC Program.

_____ _____

Signature of Applicant (Parent/Legal Guardian if Minor) **Date**