OGLALA SIOUX TRIBE
MEDICAL ASSISTANCE

ARE YOU APPLYING FOR MEDICAL ASSISTANCE FOR SELF/CHILD/EMERGENCY MEDICAL (PLEASE CIRCLE ONE)

APPLICANTS NAME:______________________________ CONTACT NUMBER:________________________

MAILING ADDRESS: ____

PLEASE COMPLETE THIS ENTIRE SECTION

PATIENTS NAME: ______________________________ PATIENTS DOB: ___________________________

DISTRICT: ___________________________ TRIBAL MEMBER: YES / NO TRIBE ENROLLED: _______________

MEDICAID CARD #: ______________________________ REFERRAL CARD: YES / NO

PLEASE ATTACH APPOINTMENT SLIP OR MEDICAL VERIFICATION . IF NO DOCUMENTATION IS ATTACHED IT WILL BE CONSIDERED INCOMPLETE

APPOINTMENT DATE: ______________________________ APPOINTMENT TIME: ____________________

MEDICAL FACILITY & ADDRESS: ____

PHYSICIAN NAME: ______________________________ CONTACT NUMBER: ______________________

TYPE OF APPOINTMENT: ____

IF OTHER MEDICAL EMERGENCY PLEASE EXPLAIN: _____________________________________

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SIGNATURE: ______________________________________ DATE: _____________________

- SIGNATURE OF DOCUMENT SERVES AS AN OFFICIAL RELEASE OF INFORMATION FOR THE OST TREASURERS OFFICE TO CROSS REFERENCE WITH DISTRICT CAPS/CSBG/ETC FOR ANY PRIOR MEDICAL ASSISTANCE/UNRETURNED T-19 STATE REIMBURSEMENT FORMS
- EMERGENCY MEDICAL ASSISTANCE WILL GO TO NEXT OF KIN ONLY

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OFFICE USE ONLY

TITLE 19 ELIGIBLE: YES / NO MEDICAL: YES / NO AMOUNT APPROVED:__________________

REMARKS: ____

SIGNATURE: ______________________________________ DATE: _____________________