STOCKBRIDGE-MUNSE HEALTH & WELLNESS

TRIBAL HEALTH FUND APPLICATION

Verification of Receipt

By signing, I am acknowledging that I have read the Tribal Health Fund Policy in its entirety and fully understand and accept its terms.

_____

Print name

_____

Signature

_____

Date

Please be sure to keep a copy of all documents that you sign for your own records.

Personal Information

Name: _____

Maiden Name: _____ Sex: Male Female

Birth date: _____ SSN: _____ Enrollment No.: _____

Physical Address: _____

Mailing Address (if applicable): _____

City: _____ State: _____ Zip: _____

Primary Phone No.: _____ Secondary Phone No.: _____

Email: _____

Insurance Information

Do you have some form of insurance coverage outside of THF? Yes No

If no, please note that you will need to apply for alternate resources before THF dollars can be allocated, per THF policy. Failure to do so will result in claims being denied.

Type(s) of insurance coverage: Medical Hospital Dental Optical

Orthodontic Pharmacy Other (please indicate): _____

Primary Insurance Company: _____

Primary Insurance Address: _____

Primary Insurance Phone No.: _____

Policy Holder Name: _____ Policy No.: _____

Secondary Insurance Company: _____

Secondary Insurance Address: _____

Secondary Insurance Phone No.: _____

Policy Holder Name: _____ Policy No.: _____

Please include a copy of the front and back of both your tribal ID and insurance cards

STOCKBRIDGE-MUNSEE HEALTH AND WELLNESS CENTER
W12802 CO HWY A
PO BOX 86
BOWLER, WI 54416
715 793-4144

Accredited by the
ACCREDITATION ASSOCIATION *for* AMBULATORY HEALTH CARE, INC

Consent to the use and disclosure of health information for treatment, payment, or health care operations

Authorization to furnish information and assignment of benefits (private insurance, Medicare and Medicaid)

The Stockbridge-Munsee Health and Wellness Center may disclose all or any part of the patient's health record to any person or corporation which is or may be liable under a contract to a hospital, medical service company, insurance company, workers compensation, public aid funds, patient's employer, Medicare, Medicaid, I.H.S., etc.

I hereby assign to the Stockbridge-Munsee Health and Wellness Center such benefits (if any) that I may have pertaining to payment for medical services and supplies furnished to me or dependents included in my insurance policy. I AUTHORIZE payment of such benefits to the Stockbridge-Munsee Health and Wellness Center. I understand this assignment will remain in effect until revoked by me in writing. A scanned copy of this assignment is to be considered as valid as the original.

Patient Name Printed _____ D.O.B. _____

Patient Signature _____ Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

My signature on this form acknowledges that I have received a copy of the Stockbridge- Munsee health and Wellness Center's Notice of Privacy Practices. I understand that this document provides an explanation of the ways in which my health information may be used or disclosed by the SMI-IWC and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding I tic privacy of my health information.

Patient name (printed): _____ Date of Birth: _____

Patient Signature: _____ Date: _____

_____ Date: _____

Signature of Patient Representative (State relationship to Patient)

Or Witness (If signature is by thumb print or mark

_____ Title: _____ Date: _____

Signature of SMHWC Staff Member

TO BE COMPLETED BY SMHWC EMPLOYEE IF FORM IS NOT SIGNED

1. Was the patient provided with a copy of the Notice of Privacy Practices? ◯Yes ◯No
2. Briefly describe efforts made to obtain the patient's acknowledgement of the Notice and explain why the patient was not able or willing to sign this form:

_____
_____
_____

_____ Title: _____ Date: _____

Signature of SMHWC Staff Member

Stockbridge-Munsee Community
Office of Accounting Services
Account Payables

AUTHORIZATION AGREEMENT FOR DIRECT DEPOSITS

Customer Name _____ _____ _____
First *Last* *MI*

_____ _____ _____ _____
Address City State Zip Code

E-Mail Address (for electronic pay stub): _____

I hereby authorize Stockbridge-Munsee Community (SMC) and my bank to automatically make deposits into my account listed above (this includes my authorization to correct entries made in error.) This authorization will remain in effect until I give written notice to cancel it.

Complete for DIRECT DEPOSIT

Bank Account

Checking Savings

It's safe and secure.

* Account Number _____

Bank Name _____

Bank Routing # _____

** **For account verification, you must attach a voided check.**

* No more lost or misplaced checks.
* Your check's automatically deposited into your account
* It eliminates a trip to the bank.

** If your bank account number has changed, you must provide a voided check or bank specification sheet.*
**Banks are very strict with their routing number to avoid any issues, please attached requested documentation.
The processing of this form will take at least *two pay periods*.

_____ _____
Signature Date

FOR ACCOUNTING SERVICES USE ONLY

_____ _____
Processed by Date