DEPARTMENT OF HEALTH & HUMAN SERVICES Public Health Service

Oklahoma City Area IHS
70 I Market Drive
Oklahoma City, OK 73114

DATE:_____

TO:_____

_____

_____

We have received a referral or emergency room notification for you, but are unable to process because your eligibility has not been established. Establishing eligibility is essential to processing the referral and determine payment or denial. Please FILL OUT THIS FORM, with the documents listed below and return to our office. Your information must be received within fifteen (15) working days from the date of this letter at the address listed above. Failure to provide the requested items or filling out this form in a timely fashion will result in no further consideration for payment of services from PRC. Return all items listed by either IHS secure email system (call PRC 405-951-6075 for assistance), mail to the address listed above, or fax to (405)951-3920.

The following items are required with the attached chart application:

- ☐ **OK Driver's License or OK State Issued Identification Card**
- ☐ **Proof of Indian Descent (CDIB or Tribal card w/blood quantum listed)**
- ☐ **Proof of Residency in your name (current utility bill, or mortgage statement, or rental agreement)**
  Physical address, not a PO Box. If no proof of residency in patient name, please contact us for additional form
- ☐ **Legal Documentation associated with your name change (Marriage or divorce papers)**
- ☐ **Insurance card (front & back) with effective date and policy holder name and date of birth.**
- ☐ **If minor, please provide Birth Certificate and parent Photo ID with current address and/or current utility bill.**

If you have any questions pertaining to this matter, please call (405) 951-6075 between the hours of 8:00 am to 4:00 pm.

If you are age 64 and under we are required to screen you for other resources such as SoonerCare. Please provide us your number of total household members and total gross income.

TOTAL IN HOUSEHOLD _____ **GROSS MONTHLY INCOME** _____

Indian Health Service
Purchased/Referred Care
Registration Application

Date: _____ Birth Sex: ☐M ☐F

1. _____

Legal Name: Last First Middle

2. _____ 3. _____ 4: Marital Status: ☐M ☐D ☐W ☐S ☐Common Law

Date of Birth Social Security Number

5. _____

Street Address City State Zip Code

6. _____ 7. _____ 8._____9. _____

Home Phone Work Phone Cell Phone Date Moved to Residence

10. Employer: _____ ☐ Full Time ☐Part Time ☐ Self Employed ☐ Retired
11. Next of Kin and/or Emergency Contact Person_____ Phone: _____

Relationship to applicant_____Address_____

12. Do you have Medicare ☐ Yes ☐ No If yes, Medicare Number_____

Part A Hospital Date: _____ Part B Medical Date_____

13. Are you a Veteran ☐ Yes ☐ No If yes, Branch_____
14. Do you have Railroad Retirement ☐Yes ☐No If yes, RR Number_____
15. Do you have Private/Group Health Insurance ☐Yes ☐ No If yes, complete the following:

_____ _____

Insurance Company Name Insurance Company Address

_____ _____

Name of Insured Patient's Relationship to Insured

_____ _____

Policy, Identification, or Social Security # Effective Date

_____ _____

Group Name Group Number of Payor Number

Failure to complete the required information will result in the denial of payment

I understand that this certification is subject to verification and fraudulent statements will result in the loss of eligibility for Purchased/Referred services. This will include the recovery of any payments by Indian Health Services upon which I will be financially responsible. *I also hereby acknowledge receipt of the Indian Health Service (IHS) Notice Privacy Practice at the following Shawnee Service Unit facility:*

_____ _____

Date Signature

Please list any family members that you consent to calling our office for appointment, payment or referral information. List their name and relationship to you in box II. Please sign and date this form to consent to our office obtaining medical records on your behalf as well.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 09-30-2023
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

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)

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
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

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)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

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.

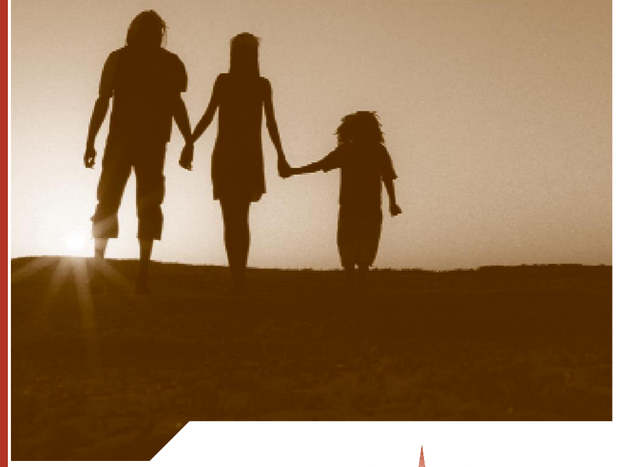
      Psychotherapy notes are often referred to as process notes, distinguishable from progress notes in the medical record. These notes capture the therapist's impressions about the patient, contain details of the psychotherapy conversation considered to be inappropriate for the medical record, and are used 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.

INDIAN HEALTH SERVICE

NOTICE OF PRIVACY PRACTICES

September 14, 2007



HIPAA

Health Insurance Portability and Accountability Act

PRIVACY RULE

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

summary of your privacy rights

i. understand your medical record/information.

Each time you visit an Indian Health Service (IHS) facility for services, a record of your visit is made. If you are referred by the IHS through the Contract Health Service (CHS) program, the IHS also keeps a record of your CHS visit. Typically, this record contains your symptoms, examination, test results, diagnoses, treatment, and a plan for future care. This information, often referred to as your medical record, serves as a:

- Plan for your care and treatment.
- Communication source between health care professionals.
- Tool with which we can check results and continually work to improve the care we provide.
- Means by which Medicare, Medicaid, or private insurance payers can verify the services billed.
- Tool for education of health care professionals.
- Source of information for public health authorities charged with improving the health of the people.
- Source of data for medical research, facility planning, and marketing.
- Legal document that describe the care you receive.

Understanding what is in your medical record and how the information is used helps you to:

- Ensure its accuracy.
- Better understand why others may review your health information.
- Make an informed decision when authorizing disclosures.

ii. your medical record/information rights.

Although your medical record is the physical property of the IHS, the information belongs to you. You have the right to:

- Inspect and receive a copy of your medical record.
- Request a restriction on certain uses and disclosures of your health information. For example, you may ask that we not disclose your health information and/or treatment to a family member. The IHS is not required to agree to your request; but if we do, we will comply with your request unless the information is needed to provide you with emergency services.
- Request a correction/amendment to your medical record if you believe the health information we have about you is incorrect or incomplete, we may amend your record or include your statement of disagreement.
- Request confidential communications about your health information. You may ask that we communicate with you at a location other than your home or by a different means of communications such as telephone or mail.
- Receive a listing of certain disclosures the IHS has made of your health information upon request. This information is maintained for 5 years or the life of the record, whichever is longer.
- Revoke your written authorization to use or disclose health information. This does not apply to health information already disclosed or used or in circumstances where IHS have taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.
- Obtain a paper copy of the IHS Notice of Privacy Practices upon request.
- Obtain a paper copy of the IHS Medical, Health and Billing Records, System Notice Number 09-17-0001, upon request.

iii. indian health service (ihs) responsibilities.

The IHS is required by law to:

- Maintain the privacy of your health information.
- Inform you about our privacy practices regarding health information we collect and maintain about you.
- Notify you if we are unable to agree to a requested restriction.
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.
- Honor the terms of this Notice or any subsequent revisions of this Notice.

The IHS reserves the right to change its privacy practices and to make the new provisions effective for all protected health information (PHI) it maintains. The IHS will post any revised Notice of Privacy Practices at public places within its health care facilities and on its web site at http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm and you may request a copy of the Notice.

The IHS understand that health information about you is personal and is committed to protecting your health information. **The IHS will not use or disclose your health information without your permission, except as described in this notice and as permitted by the Privacy Act and the IHS Medical, Health and Billing Records; System Notice 09-17-0001.**

iv. how ihs may use and disclose health information about you.

The following categories describe how we may use and disclose health information about you.

We Will use and Disclose your health information to provide your treatment. For example:

- Your personal information will be recorded in your medical record and used to determine the course of treatment for you. Your health care provider will document in your medical record his or her instructions to members of your healthcare team. The actions taken and the observations made by the members of your healthcare team will be recorded in your medical record so your health care provider will know how you are responding to treatment.
- If the IHS refers you to another health care facility under the CHS program, the IHS may disclose your health information to that health care provider for treatment decisions.
- If you are transferred to another facility for further care and treatment, the IHS may disclose information to that facility to enable them to know the extent of the treatment you have received and other information about your condition.
- Your health care provider(s) may give copies of your health information to others (health care professionals, personal representative, etc.) to assist in your treatment.

We Will use and Disclose your health information for payment purposes. For example:

- If you have private insurance, Medicare, or Medicaid coverage, a bill will be sent to your health plan for payment. The information on or accompanying the bill will include information that identifies you, as well as your diagnosis, procedures, and supplies used for your treatment.
- If the IHS refers you to another health care provider under the CHS program, the IHS may disclose your health information with that provide for health care payment purposes.

We Will use and Disclose your health information for health care operations. For example:

- We may use your health information to evaluate your care and treatment outcomes with our quality improvement team. This information will be used to continually improve the quality and effectiveness of the services we provide. This includes health care services provided under CHS program.

HIPAA

Health Insurance Portability and Accountability Act

PRIVACY RULE

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

INDIAN HEALTH SERVICE · PHS · 1955 ·

SUMMARY OF YOUR PRIVACY RIGHTS

Business associates. The IHS provides some healthcare services and related functions through the use of contracts with business associates. For example, the IHS may have contracts for medical transcription. When these services are contracted, the IHS may disclose your health information to business associates so that they can perform their jobs. We require our business associates to protect and safeguard your health information in accordance with all applicable Federal laws.

Directory. If you are admitted to an IHS inpatient facility, the IHS may use or disclose your name, general condition religious affiliation, and location within our facility, for facility directory purposes, unless you notify us that you object to this information being listed. The IHS may provide your religious affiliation only to members of the clergy.

Notification. The IHS may use or disclose your health information to notify or assist in the notification of a family member; personal representative or other authorized person(s) responsible for your care, unless you notify us that you object.

communication with family. All IHS health providers may use or disclose your health information to others responsible for your care unless you object. For example, the IHS may provide your family members, other relatives, close personal friends, or any other person you identify, with health information that is relevant to that person's involvement with your care or payment for such care.

adults and Emancipated minors with personal representatives or Legal guardians. IHS shall treat a personal representative or legal guardian of any such individual who has been declared incompetent due to physical or mental incapacity by a court of competent jurisdiction for the purposes of the use and disclosure of PHI as it relates to such personal representation.

interpreters. In order to provide you proper care and services, the IHS may use the services of an interpreter. This may require the use or disclosure of your personal health information to the interpreter.

research. The IHS may use or disclose your health information for research purposes that has been approved by an IHS Institutional Review Board (IRB) that has reviewed the research proposal and established protocols to ensure the privacy of your health information. The IHS may also use or disclose your health information for research purposes based on your written authorization.

organ procurement organizations. The IHS may use or disclose your health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of facilitating organ, eye, or tissue donation and transplant.

uses and Disclosures about Decedents. The IHS may use or disclose health information about decedents to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. The IHS also may disclose health information to funeral directors consistent with applicable law as necessary to carry out their duties. In addition, the IHS may disclose protected health information about decedents where required under the Freedom of Information Act or otherwise required by law.

treatment alternatives and other health-related Benefits and services. The IHS may contact you to provide information about treatment alternatives or other types of health-related benefits and services that may be of interest to you. For example, we may contact you about availability of new treatment or services for diabetes.

food and Drug administration. The IHS may use or disclose your health information to the Food and Drug Administration (FDA) in connection with a FDA-regulated product or activity. For example, we may disclose to the FDA information concerning adverse events involving food, dietary supplements, product defects, or problems, and information needed to track FDA-regulated products or to conduct product recalls repairs, replacements, or lookbacks (including locating people who have received products that have been recalled or withdrawn), or post marketing surveillance.

appointment reminders. The IHS may contact you with reminder that you have an appointment for medical care at an IHS facility or to advise you of a missed appointment.

Workers compensation. The IHS may use or disclose your health information for workers compensation purposes as authorized or required by law.

public health. The IHS may use or disclose your health information to public health or other appropriate government authorities as follows:

(1) The IHS may use or disclose your health information to government authorities that are authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or conducting public health surveillance, investigations, and interventions;

(2) The IHS may use or disclose your health information to government authorities that are authorized by law to receive reports of child abuse or neglect, and

(3) The IHS may use or disclose your health information to government authorities that are authorized by law to receive reports of other abuse, neglect, or domestic violence as required by law, or as authorized by law if the IHS believes it is necessary to prevent serious harm. Where authorized by law, the IHS may disclose your health information to an individual who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition. In some situations (for example, if you are employed by IHS or another component of the Department of Health and Human Services (HHS), or if necessary to prevent or lessen a serious and imminent threat to the health and safety of an individual or the public), the IHS may disclose to your employer health information concerning a work-related illness or injury or a workplace-related medical surveillance.

correctional institution. If you are an inmate of a correctional institution, the IHS may use or disclose to the institution, health information necessary for your health and the health and safety of other individuals such as officers or employees or other inmates.

Law Enforcement. The IHS may use or disclose your health information for law enforcement activities as authorized by law or in response to a court of competent jurisdiction.

health oversight authorities. The IHS may use or disclose your health information to health oversight agencies for activities authorized by law. These oversight activities may include: Investigations, audits, inspections, and other actions. These are necessary for the government to monitor the health care system, government benefit programs, and entities subject to government regulatory programs and/or civil rights laws for which health information is necessary to determine compliance. The IHS is required by law to disclose protected health information to the Secretary, HHS, to investigate or determine compliance with the HIPAA privacy standards.

members of the military. If you are a member of the military services, the IHS may use or disclose your health information if necessary to the appropriate military command authorities as authorized by law.

compelling circumstances. The IHS may use or disclose your health information in certain other situations involving compelling circumstances affecting the health or safety of an individual. For example, in certain circumstances:

(1) The IHS may disclose limited protected health information where requested by a law enforcement official for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person;

(2) If you are believed to be a victim of a crime, a law enforcement official requests information about you and we are unable to obtain your agreement because of incapacity or other emergency circumstances, we may disclose the requested information if we determine that such disclosure would be in your best interests;

(3) The IHS may use or disclose protected health information as we believe is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person;

(4) The IHS may use or disclose protected health information in the course of judiciary and administrative proceedings if required or authorized by law;

(5) The IHS may use or disclose protected health information to report a crime committed on IHS health facility premises or when the IHS is providing emergency health care;

(6) The IHS may use or disclosure PHI during a disaster and for disaster relief purposes; and

(7) The IHS may make any other disclosures that are required by law.

Non violation of this Notice. The IHS is not in violation of this Notice or the HIPAA Privacy Rule if any of its employees or its contractors (business associates) disclose protected health information under the following circumstances:

1. **Disclosures by Whistleblowers.** If an IHS employee or contractor (business associate) in good faith believes that the IHS has engaged in conduct that is unlawful or otherwise violates clinical and professional standards or that the care or services provided by the IHS has the potential of endangering one or more patients or members of the workplace or the public and discloses such information to:

   a. A Public Health Authority or Health Oversight Authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions, or the suspected violation, or an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the IHS; or

   b. An attorney on behalf of the workforce member, or contractor (business associate) or hired by the workforce member or contractor (business associate) for the purpose of determining their legal options regarding the suspected violation.

2. **Disclosures by Workforce member crime victims.** Under certain circumstances, an IHS workforce member (either an employee or contractor) who is a victim of a crime on or off the IHS facility's premises may disclose information about the suspect to law enforcement official provided that:

   a. The information disclosed is about the suspect who committed the criminal act.

   b. The information disclosed is limited to identifying and locating the suspect.

any other uses and disclosures will be made only with your written authorization, which you may later revoke in writing at any time. (such revocation would not apply where the health information already has been disclosed or used or in circumstances where the ihs has taken action in reliance on your authorization or the authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim under the policy or the policy itself.)

To exercise your rights under this Notice, to ask for more information, or to report a problem contact the Chief Executive Officer or the Service Unit privacy official at:

If you believe your privacy rights have been violated, you may file a written complaint with the above individual(s) or the Secretary, U.S. Department of Health and Human Services, Washington, D.C. 20201. There will be no retaliation for filing a complaint.

Effective Date: September 14, 2007

Better Healthcare for Indian People; Today and Tomorrow

Oklahoma City Area Indian Health Service
Purchased/Referred Care
701 Market Drive, Suite 143
Oklahoma City, OK 73114
(405) 951-6075
www.ihs.gov

Revised September 2019

Oklahoma City Area
Indian Health Service

Purchased/ Referred Care

- **Purchased/Referred Care (PRC) is health care purchased by the Indian Health Service (IHS) from non IHS providers and facilities when direct services of care are not available at an Indian Health System Clinic or Hospital.**
- **Due to limitation of PRC resources, funds must be managed in accordance with established medical priorities.**
- **PRC funding is only used for referred and emergency services.**

How Does PRC Work

Requests for PRC are reviewed weekly and ranked according to relative medical priority. Requests are approved for PRC payment to the extent of available resources for the review period.

Eligibility

Patients must meet eligibility, notification, pre-authorization, and alternate resource requirements of the PRC program.

To be eligible for PRC funding, you must meet all of the 5 requirements listed below:

1. be a member of, or descendent of a federally recognized Indian tribe and provide appropriate documentation such as a Certificate of Indian Blood (CDIB) or birth certificate reflecting descendancy from an otherwise enrolled tribal member. A non-Indian pregnant woman with an eligible Indian's child is eligible for direct and PRC care during pregnancy and for 6 weeks through post partum for OB related care;

2. reside on a permanent basis within a PRC Delivery Area (PRCDA) that includes the state of Oklahoma, Brown, Doniphan, Douglas, Jackson Counties in Kansas, Richardson County, Nebraska and Maverick County, Texas;

The following individuals are also eligible:

A. Full-time boarding school, college, vocational, or other academic students who are living away from the PRCDA specifically for the purpose of education. Haskell Service Unit covers all full time students at Haskell Indian Nations University.

B. Person who is temporarily away from the PRCDA due to travel, employment, etc.

C. Non-Indian adopted, step children, and foster children of an otherwise eligible Indian parent. Indian children placed in foster care away from the PRCDA by order of a court of competent jurisdiction and who were eligible for PRC at the time of the court order shall continue to be eligible.

D. Maintain close economic and social ties with that federally recognized tribe or tribes.

Accessing PRC

3. Payment for medical care outside an IHS facility can only be authorized by a PRC official if funds are available. PRC is also the Payor of Last Resort so all other payors such as Medicaid, Medicare and private insurance must be exhausted first. To access payment for services through PRC, after all other payors, a patient must first either have a pre-authorized referral for a specific date of service or emergency service. Keep the following specifics in mind to ensure that PRC has authorized the care.

Referrals

A. Referrals are written by an Indian Health System provider(s) for service(s). A referral, however, does not constitute authorization for payment until approved by PRC. If funds are not available the referred service(s) will be deferred or denied. All approved referrals are date specific and any further treatment requires a new approved referral.

Appointments

B. It is important that all referral appointments are kept. Patients are asked to cancel any appointments at least 3 days prior to the scheduled appointment date by a telephone call to PRC. Any changes to the appointment must be made by the PRC staff in order to ensure authorization for payment.

Verification

C. Patients are to take alternate resource(s) identification with them to their appointment to ensure providers have accurate and appropriate billing information.

Emergency Services

D. PRC must be contacted within 72 hours of receiving emergency care other than at a ITU. For an elderly or disabled person receiving emergency care, this time may be extended to 30 days. If a patient is unable to contact PRC, a person acting on their behalf must contact PRC within the same time limits. All non-emergency care must be pre-authorized by PRC before receiving medical treatment.

Alternate Resources

4. You must apply for all resources available to you such as: Medicaid, Medicare, Worker's Compensation, Vocational Rehabilitation, Auto Insurance and other personal injury or liability coverage. PRC staff and/or Benefit Coordinators can assist with the application process for alternate resources. Failure to exhaust available or potentially available alternate resources may result in denial of payment.

Claims Coordination

5. Patients are to provide the PRC Office copies of the following documents for claims processing:

Alternate resource(s) payment information
Explanation of Benefits Report
Remittance Statements/Reports
Other documentation of payments
Responses to application for alternate resources
Medical records

Denials

If your request for PRC funding is denied, you will receive a letter informing you of the denial. Sometimes all that is needed is more information. If you already went to a non-Indian Health Service provider for your care a letter of denial for payment will also be sent to them. You have 30 days to request reconsideration in writing. Please address the appeal letter to the PRC program listed at the bottom of the denial letter.