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CITIZEN POTAWATOMI NATION

HEALTH AID PROGRAM

Dear Tribal Member,



Please read all **new** guidelines before filling out the application.



Please make sure to include all requested information on the application, including vendor and insurance information.



All incomplete applications will be mailed back to applicant for completion.

**Health Aid Program
General Information, Guidelines and Application**

**Applicant must be an enrolled Citizen Potawatomi Nation Tribal Member and
born by December 31, 1976.**

THE FOLLOWING MUST BE COMPLETED

Application must be completed by Tribal Member.

The Social Security Number or Tax ID Number is required for a check to be issued.

Detailed Itemized Statement: (Must be from Doctor or Business)

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|--|
| Patient's Name, Date of Service, Description of Device, Itemized Cost of device, Vendor's name, address, phone number and Tax ID Number (if there is a balance due). |
|--|

It is the Tribal Member's responsibility to include all needed information. The Health Aid Program will not be responsible for gathering missing information from the Vendor. This is due to the Privacy Laws that are now in place. Information is not allowed to be shared without appropriate paperwork filled out by the patient.

Program monies are to be used for the purchase of:

Bridgework, Crowns, Dentures, Partial, Hearing Aids (1 per Ear), CPAP Machines, CPAP Equipment/Supplies (Once a year), Mobile Chairs, Mobile Chair lifts and ramps for vehicles, Prosthetic Devices, and Wheelchairs. The Health Aid Program will pay on 1 repair per year. Corrective Eye Wear can be obtained with fund up to \$250 per year.

PAYMENT:

1. If there is a balance due the check will be made payable to the Vendor. This is due to the amount of banks that will no longer process two party checks. The Tax ID Number must be listed on the application or Itemized Statement. A check will not be issued until required information is received.
2. Checks will be void after 90 days and will not be reissued.
3. The Health Aid Program does not pay on estimates. If an estimate is received the Health Aid Program will issue an approval letter. Once the required information is received the payment can be processed.

AUTHORIZED EXPENDITURE LIMITS:

Expenditures shall not exceed 75% of the cost of the device(s). During the program year, no one individual may be authorized to collect more than \$750.00. The Health Aid Program does not pay 100% of the cost of the prosthetic device(s). The Health Aid Program will pay 75% up to \$750.00 after insurance, discounts, coupons and groupons have been deducted from the amount of the prosthetic device(s). The Health Aid Program does not pay or reimburse for the cost of groupons. If corrective Eye Wear is obtained the Health Aid Program will pay 100% of the \$250.00 allowable.

Health Aid Program General Information, Guidelines and Application

AUTHORIZED EXPENDITURE LIMITS CONTINUED:

If the Tribal Member has insurance the Health Aid Program will pay on the Patient's Responsibility for the device(s) applied for. The Health Aid Program will not pay without a copy of the Explanation of Benefits or Itemized Statement showing what insurance paid on each listed item. This can not be an estimate. If there is not a Patient Responsibility amount listed it will be assumed the Tribal Member's responsibility is \$0.00. **The program year is January through December. Applications are considered in the year they are received, not by the date of service.**

APPROVAL:

Completed applications will be individually and collectively reviewed on a weekly basis. Applications will not be considered if information is lacking.

The following criteria must be met to be eligible:

1. Tribal Membership Requirements- must be enrolled with the Citizen Potawatomi Nation and born by December 31, 1976.
2. Need for Device Must Exist- must be prescribed by a licensed health professional.
3. **Applications received after the last working day in December will be considered the following year.**

DENIALS:

1. Any itemized statements with a date of service over a year old will not be considered.
2. Applicant does not meet membership requirements.
3. Applicant has reached maximum amount of \$750.00 for the year running January through December.
4. The Health Aid Program will not pay for examinations, contact fitting fees, procedures, x-rays, routine dental work, surgery, extractions, medication, orthodontics, root canals, crown buildup &/or pins, bone grafting, warranties, catheters, blood pressure machines, weight scales, tens unit, lens replacement (due to cataract surgery), hip or knee replacements, remodeling due to handicap accessibility (wheelchair ramps, handicap bathrooms, etc.), shipping, processing fees or taxes.

Health Aid Program Application

Citizen Potawatomi Nation
Health Aid Program
2307 S. Gordon Cooper Drive
Shawnee, OK 74801
(405)964-4025 or 1-800-880-9880 Fax (405)964-5791

Amber Brewer
ARBrewer@potawatomi.org

**** Please note: This Process takes 4-6 weeks ****

**** All checks that are issued will be void after 90 days and will not be reissued ****

**** Checks will not be issued without a Social Security Number or W9 ****

**** Eyewear is only covered up to \$250.00.*****

This application is to be filled out by the Tribal Member only. Please fill out the complete application including Vendor/Retailer information.

First: _____ Last: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____ Tribal ID #: _____

Please check (X) one of the following prosthetic device(s) applying for:

Prosthetic Description _____

Crown(s) } *Circle The
 Bridgework } Tooth #(s)*

| | | | | | | | | | | | | | | | | | |
|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 | 26 | 27 | 28 | 29 | 30 | 31 | 32 | | | | |

Eye glasses Prescription Sunglasses Contacts

Wheelchair Mobile Chair Mobile Chair lift or ramp for vehicle

Partial(s) Upper Lower Both Denture(s) Upper Lower Both

Hearing Aid(s) Right Left Both CPAP Machine Equipment/Supplies

Vendor/Retailer Name _____ Phone: _____

Full Address: _____

Tax ID Number: _____

The Tax ID Number is only needed if there is a balance due. The Check will be made out to the Vendor only unless the Itemized Statement shows a \$0 balance due.

Do you have insurance that will assist with this device? Yes No

If so, you must send an Explanation of Benefits before the Health Aid Program will pay on the device.

I have received and read the Health Aid Program guidelines.

Tribal Member Signature: _____ Date: _____