

DATE STAMP

Provider/Patient Full Name
Address
City, State Zip Code

Dear Provider/Patient Full Name:

The Affordable Care Act, enacted on March 23, 2010, reauthorized and amended the Indian Health Care Improvement Act (IHCIA). The IHCIA provides that patients are not liable for payment of services authorized and approved for payment under a Contract Health Services (CHS) program, which pays for referrals for healthcare services to non-IHS providers.

Specifically, section 222 of the IHCIA [25 U.S.C. § 1621u] provides:

(a) NO PATIENT LIABILITY. A patient¹ who receives contract health care services that are authorized² by the Service³ shall not be liable for the payment of any charges or costs associated with the provision of such services.

(b) NOTIFICATION. The Secretary shall notify a contract care provider and any patient who receives contract health care services authorized by the Service that such patient is not liable for the payment of any charges or costs associated with the provision of such services not later than 5 business days after receipt of a notification of a claim by a provider of contract care services.

(c) NO RECOURSE. Following receipt of the notice provided under subsection (b), or, if a claim has been deemed accepted under section 220(b), the provider shall have no further recourse against the patient who received the CHS services.

In summary, a patient is not liable for services that have been authorized for payment by a CHS program carried out by the Indian Health Service (IHS) or a Tribal health program. Providers are prohibited from collecting any payments for these services from the patient, whether directly or through referral to an agent for collection. Please note that not all visits or referrals of IHS eligible patients to non-IHS providers are authorized for payment.

Enclosed is a sample Agency Form 843-1A used to authorize payment for contract health services from IHS. Please note that a CHS program carried by a Tribal health program may use

¹ Patients that are eligible per CHS regulations

² Authorized and approved for payment

³ Program carried out by IHS or by a Tribe through an Indian Self Determination Act contract

a similar form when authorizing care. If you have questions about the CHS program, please contact our office at [insert phone number]. Thank you.

Sincerely,

Name of Entity/Sender:	[Insert Name of I/T Site]
Contact-Position/Office:	[Insert Position/Office]
Address:	[Insert Street Address, City, State & Zip Code of Entity]
Phone Number:	[Insert Entity Phone Number]

Enclosure