New Patients

Information needed to complete a chart

1. PATIENT REGISTRATION FORM

General information

2. SIGNATURE HIPAA

Privacy policy brochure

3. SIGNATURE A.O.B.

Assignment of Benefits (insurance information)

(the following may be brought in at a later date or fax copies)

4. BIRTH CERTIFICATE/PATERNITY PAPERS—AFFIDAVIT

5. SOCIAL SECURTIY CARD

To verify social security number

6. TRIBAL ENROLLMENT

Tribal ID or Enrollment papers

7. INSURANCE INFORMATION

Medicaid/Medicare/Private Insurance/Workman's Compensation/Motor Vehicle

PATIENTS KEEP THIS PAGE

Telephone: 605-355-2500
Fax: 605-355-2557
Attn: Patient Registration

Identifying and obtaining appropriate information for
Direct and Contract Health Service Care

General Eligibility Requirements:

1. Must be an enrolled member OR descendent of enrolled member of a Federally Recognized Tribe.
2. Eligibility will be extended to non-Indian in only three (3) situations.
   A.) Non-Indian woman pregnant with eligible Indian's child for duration of pregnancy through six (6) weeks post-partum for pregnancy related care only.
   B.) Non-Indian member of eligible Indian's household—public health hazard only.
   C.) Non-Indian: adopted, foster, step-child(ren) of eligible Indian until age of 19 years (PL100-713)

Note: Non-Indian patients who do not meet the above but present at I.H.S. emergency room for emergency care (prevent immediate death, serious impairment to life, limb, senses) can be treated, stabilized and routed to a non-I.H.S. facility with patient responsible for costs.

Note: Non-Indians who do not meet the above, present at I.H.S. are to be informed they are not eligible and must obtain their non-emergency care elsewhere.

Suggestions on information needed to open a medical chart at I.H.S.

1. Proof (enrollment paper or tribal identification card) of being member or descendent of member (parent(s) or grandparent(s) enrollment papers, birth certificate, etc. to show lineage.
2. Proof of pregnancy (can be performed at I.H.S.) of non-Indian woman with:
   A.) marriage certificate if married to eligible Indian
   B.) if non-Indian woman is not married to eligible Indian—notarized paternity affidavit.

3.Public Law 100-713 "Health Services for ineligible Persons"
   A.) Must be 19 years of age
   B.) if not adopted, must be residing with eligible Indian with notarized statement from eligible Indian attesting to the fact that child(ren) are under his/her guardianship and effective date (i.e. court papers) and proof from school child(ren) are enrolled in school with beginning date, who is listed as parents or guardians.

Acceptable forms of proof to determine eligibility and residency for C.H.S. Program:

(Copies to me made for C.H.S. files)

- Driver's license or State ID
- Welfare/Child Care receipts
- State Records
- Homeowner or Tenant Records
- Military Records
- Employment Records within 90 days
- School Records
- Federal Records
- Support Payment Records
- Utility Bills within 90 days
- Vehicle Records
- Notarized letter from family member stating patient resides with them permanently.
- Notarized letter from Tenant Agreement or Property Management stating permanent residence.

Sioux San Hospital
3200 Canyon Lake Dr
Rapid City, SD 57702
605-355-2500

Date: _____
Chart Number: _____

DEMOGRAPHIC INFORMATION

Name:(LAST)_____(FIRST)_____,(MIDDLE)_____

OTHER NAMES : (MAIDEN, AKA): _____

MARITAL STATUS: SINGLE—MARRIED—DIVORCED—WIDOWED—SEPERATED

DATE OF BIRTH: (MONTH) _____ (DAY) _____ (YEAR) _____ PLACE OF BIRTH: (CITY AND STATE) _____

SOCIAL SECURITY NUMBER: _____ / _____ / _____ ---------- GENDER: (CIRCLE) Male/Female

MAILING ADDRESS: _____ (CITY)_____ (STATE) _____ (ZIP CODE) _____

LOCATION TO HOME (PHYSICAL LOCATION):_____

HOW LONG HAVE YOU RESIDED HERE: _____ RELIGIOUS PREFERENCE: _____

PHONE NUMBER: (HOME) (_____) _____-_____ (OTHER) (_____) _____-_____ (CELL/MSG) (_____) _____-_____

DO YOU HAVE ACCESS TO THE INTERNET: (CIRCLE) YES / NO—IF YES, WHERE: (CIRCLE) HOME—WORK—SCHOOL—LIBRARY—MOBILE

DO WE HAVE PERMISSION TO EMAIL YOU NOTICES? (CIRCLE) YES / NO EMAIL ADDRESS: _____

DO YOU HAVE AN ADVANCED DIRECTIVE? (Circle) YES or NO If YES, Please provide a copy for our records.

If YES, is it a: ___ Power of Attorney or ___ Living Will

EMPLOYMENT INFORMATION

EMPLOYER : (NAME)_____ (WORK) (_____) _____-_____

EMPLOYER ADDRESS:_____ CITY _____ STATE _____ ZIP CODE _____

ETHNICITY—*if Native American, you are required to provide proof, (TRIBAL ID, ENROLLMENT PAPERS, OR DECENDENCY)*

WHAT IS YOUR ETHINICITY/RACE: _____

PRIMARY LANGUAGE SPOKEN IN THE HOME: _____

ARE YOU ENROLLED IN A FEDERALLY RECOGNIZED TRIBE? YES / NO IF NOT, ARE YOU A DECENDANT: YES / NO

TRIBAL AFFILIATION: (WHERE ARE YOU ENROLLED? Which Tribe are you a descendant of?) _____

MOTHERS INFORMATION:

MOTHERS **MAIDEN** NAME: FIRST _____ MIDDLE _____ LAST _____

WHERE WAS SHE BORN? CITY _____ STATE _____ WHERE IS SHE ENROLLED? _____

MOTHERS EMPLOYER: _____ WORK NUMBER: (_____) _____-_____

MONTHERS EMPLOYER ADDRESS: _____ CITY _____ STATE _____ ZIP CODE_____

ANY ALTERNATE PHONE NUMBERS SHE CAN BE REACHED AT: (_____) _____-_____

FATHERS INFORMATION:

FATHERS NAME: FIRST _____ MIDDLE _____ LAST _____

WHERE WAS HE BORN? CITY _____ STATE _____ WHERE IS HE ENROLLED? _____

FATHERS EMPLOYER: _____ WORK NUMBER: (_____) _____-_____

FATHERS EMPLOYER ADDRESS: _____ CITY_____ STATE_____ ZIP CODE_____

ANY ALTERNATE PHONE NUMBERS HE CAN BE REACHED AT: (_____) _____-_____

Newborn patients will go by mothers maiden name unless a Marriage Certificate is presented before birth, or Paternity Papers/Birth Certificate for the patient is presented.

(Turn Page Over)

Date: _____
Chart Number: _____

SPOUSE INFORMATION:

NAME OF SPOUSE: _____ PHONE NUMBER: (_____) _____-_____

SPOUSE'S EMPLOYER: _____ SPOUSES WORK NUMBER: (_____) _____-_____

SPOUSES EMPLOYER ADDRESS: _____ CITY _____ STATE _____ ZIP CODE _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____ PHONE (_____) _____-_____

MAILING ADDRESS: _____ (CITY)_____ (STATE) _____ (ZIP CODE) _____

NEXT OF KIN—SEPARATE FROM EMERGENCY CONTACT

NAME: _____ RELATIONSHIP TO PATIENT: _____ PHONE (_____) _____-_____

MAILING ADDRESS: _____ (CITY)_____ (STATE) _____ (ZIP CODE) _____

MILTARY SERVICE

Have you ever served in the United States military? (CIRCLE) **YES NO**

If you answered "**YES**" list the branch, dates, and type of discharge for all active duty.

If your only active duty was training in the Reserves or National Guard, answer "NO."

Branch	From: MM/DD/YYYY	To: MM/DD/YYYY	Type of Discharge

CONTRACT HEALTH SERVICE

I understand that I am required to provide proof residency, meet medical priority requirements, exhaust all alternate resources, and meet notification requirements to be eligible for Contract Health Services.

ANY FALSIFICATION OF ANY INFORMATION MAY BE REASON FOR DENIAL FOR SERVICES OR ELIGIBILITY.

Patients Signature/Parent or Legal Guardian: _____ Date: _____

Patient must be 18 years of age or older to be seen for medical appointments unless accompanied by a parent or an adult.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Rapid City IHS Service Unit
3200 Canyon Lake Drive
Rapid City, SD 57702

Date: _____
Chart Number: _____

Acknowledgement of Receipt of IHS Notice of Privacy Practices

I hereby acknowledge receipt of the INDIAN HEALTH SERVICE (IHS) Notice of Privacy Practices at:

Rapid City IHS Service Unit
3200 Canyon Lake Drive
Rapid City SD 57702
(605) 355-2500

_____ _____
Signature of Patient Date

_____ _____
Signature of Patient Representative Date

Relationship: _____ Or Witness (if signature it by thumbprint)

_____ _____
Signature and Title of IHS Employee Date

For Patients Unable to Acknowledge Receipt

I hereby certify that the patient was unable to acknowledge receipt of the IHS Notice of Practices because:

_____

_____ _____
Signature of IHS Staff Date

Date: _____
Chart Number: _____

Benefits Coordinator General Questionnaire

1) Do you currently have insurance coverage? **Yes** **No**
   If so which one's? (Please circle)

   Medicaid (T19/Chips) - Medicare - Private Insurance - Tricare

   VA medical benefits - Workers Compensation - Motor Vehicle Accident

*Policy number:*_____ *Policy number:*_____

PLEASE PRESENT INSURANCE CARD TO THE STAFF!

2) Are there any children in the home under the age of 18 (19 if full-time student) who does not have health insurance?

   Yes **No**

3) Have you applied for Medicaid and been denied? **Yes** **No**

4) Are you 65 or older? **Yes** **No**

5) Would you like more information on Part D (pharmacy) extra help to see if you may qualify?

   Yes **No**

6) Are you disabled? **Yes** **No**
   If so have you applied for disability? **Yes** **No**
   If **yes** what is the status of your application?

   Approved **Denied** **Appealed** **Unsure**

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Rapid City IHS Service Unit
3200 Canyon Lake Drive
Rapid City, SD 57702

Date: _____
Chart Number: _____

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS FOR MEDICARE

*POLICY HOLDER'S NAME:*_____

*D.O.B:*_____ *SS #*_____

*CURRENT ADDRESS:*_____

******** Current address important this is where the new card will be sent if one is needed ********

*PHONE #:*_____

The Indian Health Service may disclose all or any part of the patient's record to any person or corporation, which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to hospital or medical service companies, Insurance Companies, Workman's Compensation, Medicare, and Medicaid funds of the patient's employer.

I hearby assign, transfer and set over to Rapid City Sioux San Hospital, Indian Health Service all my rights, title and interest to my medical reimbursement benefits under my Medicare recipient number

******* I authorize the release of any information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.******

THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE. IF ANY OF THIS INFORMATION MAY CHANGE I WILL BRING IN THE CORRECT INFORMATION.

_____ _____
SIGNATURE OF POLICY HOLDER *DATE*

*********To be filled out by Social Security Administration*********

I hereby authorize the Patient Benefits Coordinator of the Rapid City Service Unit (Indian Hospital) to receive my Medicare eligibility information. Please provide them with the following:

*MEDICARE NAME:*_____

*MEDICARE NUMBER:*_____

*DATE OF BIRTH:*_____

*Part A. Effective Date:*_____ *Part A End Date:* _____

*Part B. Effective Date:*_____ *Part B End Date:*_____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Rapid City IHS Service Unit
3200 Canyon Lake Drive
Rapid City, SD 57702

Date: _____
Chart Number: _____

Private Insurance/Pharmacy

(copy and attach insurance card)

Patient Name: _____ **Chart #** _____

Policy Holder Information

Policy Holder: _____ **Medicare Supplement: Y N**

Chart #: _____ **[ ] Non-Registered**

Insurance Co: _____

DOB: _____ **SS#:** _____

Employer: _____

Address: _____ **Work Phone#:** _____

Retired: Y N Date: _____ **Veteran: Y N Military Branch:** _____

Plan: _____ **Coverage:** _____
(Example: Basic, Standard, etc.) **(Example: Dental, Optometry, etc.)**

PLAN MEMBER NAME	DOB
_____	_____
_____	_____
_____	_____
_____	_____

****

PRIVATE INSURANCE and RX Carrier

The Indian Health Service may disclose all or any part of the patient's record to any person or corporation, which is or may be liable under a contract to the hospital, the patient, a family member and/or employer of the patient for all or part of the hospital's charge, including but not limited to hospital or medical service companies, **Private Insurance Companies, Workman's Compensation, Medicare, Medicaid** funds of the patient's employer.

I hereby assign, transfer and set over to Rapid City Sioux San Hospital, Indian Health Service all my rights, title and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

****

Signature: _____ **Date:** _____

DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Rapid City IHS Service Unit
3200 Canyon Lake Drive
Rapid City, SD 57702

Date: _____
Chart Number: _____

PHARMACY

RX Carrier: _____ **Phone:** _____

Policy Holder: _____ **Chart #:** _____

ID#: _____ **Group#:** _____

DOB: _____ **SS#:** _____

Employer: _____

Address: _____ **Phone#:** _____

NOTE: When verifying inquire about additional pharmacy coverage thru alternate pharmacy carrier.

PLAN MEMBER NAME	DOB
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____