

**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**

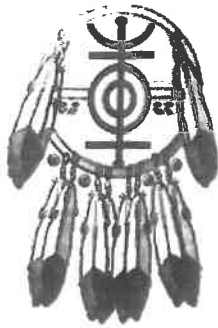
Authorization to furnish information and assignment of benefits (private insurance, Medicare and Medicaid)

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 _____

* No more lost or misplaced checks.

Bank Name _____

* Your check's automatically deposited into your account

Bank Routing # _____

* It eliminates a trip to the bank.

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

** 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 _____



Processed by _____

Date _____