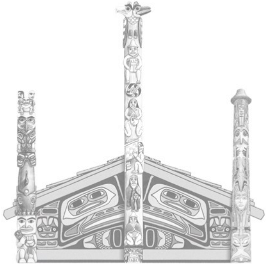


Ketchikan Indian Community

Tribal Health Clinic

2960 Tongass Avenue
Ketchikan, Alaska 99901
Ph: 907-228-9200 option 2
Fax: 800-887-8796
www.kictribe.org

Application for Health Care Services

Take the time to complete the attached application and forms and please remember to **sign and date them.**

This application can be returned in person to:

KIC Tribal Health Clinic
Patient Access / Registration
2960 Tongass Avenue
Ketchikan, Alaska 99901-5742

You may also mail the applications to the address above as well.

The following documents are required with your tribal health application:

Copies of these documents are acceptable if you are mailing the application in.

- ☐ Tribal card or certification from a **Federally Recognized Tribe**
- ☐ Birth Certificate / Photo Identification (e.g. State Issued Identification or Driver's License)
- ☐ Social Security Card
- ☐ Insurance Cards (Private, Alaska Medicaid / Medicare, VA)
- ☐ Proof of income if you do not have insurance (Medicaid denial letter)

In addition to the above, if you are a KIC Tribal member or child of a KIC Tribal member living in Ketchikan, we will also need a copy of the following:

- ☐ 2 items from the Residency Documents list provided with this packet.

Normal processing time for applications received by the Patient Access staff will be at least 2– 4 hours from the time received. Expedited processing will be done in emergency situations only.

After your application has been processed, you will receive a letter informing you if your application has been approved or denied for services.

KIC Tribal Health Clinic ● Patient Registration Services

KIC Tribal Health Clinic
2960 Tongass Avenue
Ketchikan, Alaska 99901
Telephone: 907-228-9200 Option 2
Fax: 800-887-8796
Hours: Mon - Tues - Thurs - Fri 8:00 a.m. - 5:00 p.m.
Wed 1:00 p.m. - 5:00 p.m.
Closed on weekends & holidays

Business Office Staff

Patient Access / Medical Schedulers

Erin Effenberger	907-228-9402
Theo Benson	907-228-9223

Patient Benefits Coordinator

Candice Arrington	907-228-9375

Patient Access / Registration

Erica Hoff	907-228-9407
Shasta Finger	907-228-9447
Evelyn Guthrie	907-228-9367

BH Patient Access / Registration

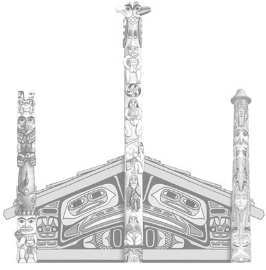
Joanne Ray	907-228-9203

Who Is Eligible For Services?

American Indians / Alaska Natives from federally recognized tribes are eligible for Direct Services. Direct Services include services provided by KIC Tribal Health Clinic that are available on-site, unless otherwise noted.

How Do I Register?

1. New patients must submit a Patient Registration Packet and copies of all required documentation
2. A complete Patient Registration Packet must be received prior to scheduling your first appointment
3. Once all required documents are received, they will be reviewed for determination of eligibility. This process normally takes two to three business days, but can be expedited in case of a true medical emergency.
4. As soon as eligibility is determined, the applicant will be notified by mail or phone.
5. Patient Registration Packets are available at all KICTHC locations. Please call us if you would like to receive a Patient Registration Packet by mail
6. Additional consent forms and authorizations may be required onsite.



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APPLICATION FOR SERVICE

Last name:___________________________________ **First name**: __________________________________

Preferred name: ____________________________ **Middle Name, Suffix**:___________________ ______

Previous Name:______________________________ **Gender**: (F) / (M)
(Last) (First)

DOB:____/_____/______ **SSN**:________________ **Mailing Address**:_____________________________

City: ____ **State**:_______________ **Zip Code**:___________

Home Phone:(____)______-________ **Mobile Phone**:(____)______-________

Work Phone:(____)______-________ **Consent to text**: (Y) / (N) **Veteran**: (Y) / (N)

Patient email: _______________________________ **Contact Preference**: (Phone) (E-mail) (mail)

Preferred Provider: __________________________ **Marital Status**: _______________________________

Tribal affiliation:____________________________ **Tribal Enrollment #**:__________________________

Blood Quantum: ______________________________ **Guardian Name**:_____________ _______________
(Last) (First)

Emergency Contact:__________________________ **Next of Kin**: ________________________________

Relationship:____________ **Phone**:_____________ **Relationship**:____________ **Phone**:_____________

Insurance Information

If available, please provide proof of insurance.

Primary Insurance:____

☐ Medical ☐ Dental ☐ Rx (Policy Number) (Group Number)

Secondary Insurance:____

☐ Medical ☐ Dental ☐ Rx (Policy Number) (Group Number)

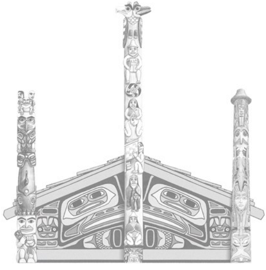
“I request that payment of authorized benefits be made on my behalf to KIC Tribal Health Clinic for services furnished to me by KIC providers

(Signature of Patient, Guardian or Responsible Party) (Date Signed)

I authorize KIC Tribal Health Center and KIC Providers to release any medical information necessary for diagnosis and further treatment, or other information to process this claim. I permit a copy of this authorization to be used in place of the original.

____

(Signature of Patient, Guardian or Responsible Party) (Date Signed)



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Recipient Name:____

Recipient Privacy Rights (Public Law 93-579) I understand that the information given by me and/or collected is necessary for Ketchikan Indian Corporation Tribal Health (**KICTHC**) to provide for my well being. Furthermore I have been informed that my records shall not be disclosed to any other agency or person without my signed consent.

Assignment of Benefits (AOB) I understand **KIC THC** has a right of recovery and reimbursement from certain third parties for medical expenses paid on my behalf to the extent that such costs are covered. This AOB authorization is in effect until revoked by patient in writing. Further, I understand that **KIC THC** may bring a claim or cause of action against the third party for recovery of such medical expenses.

Therefore, I agree as follows:

1. To assign to **KICTHC** any claim of cause of action against the third party to the extent of the medical expenses paid, or any portion thereof;
2. To furnish such information as may be requested concerning the circumstances giving rise to the injury or disease for which care and treatment is being given and concerning any action instituted by or against a third party;
3. To notify **KICTHC** of a settlement with, or an offer of settlement, for myself or my dependents;

I hereby authorize **KICTHC** to furnish information to insurance carriers and other third party payers concerning my illness and treatment, and hereby assign all payments for medical services rendered to myself or my dependents.

Release of Information I authorize **KIC THC** to collect information on behalf of myself and my dependents. I understand that information received by **KIC THC** will be kept confidential, and used for professional purposes only in terms of facilitating services for me and my dependents. I acknowledge that **KIC THC** is the **Payer of Last Resort,** and therefore **I must apply for and accept all medical benefits and/or alternate resource coverage when available.**

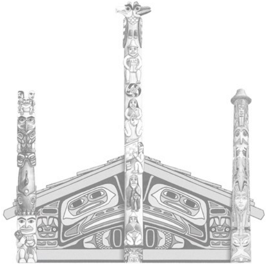
Consent to Services Recipient hereby consents to any services provided in connection with Recipient's treatment by Ketchikan Indian Corporation Tribal Health Clinic (**KIC THC**) health service providers and by independent health service providers affiliated with KIC THC. These services may include, but are not limited to, inpatient, outpatient, and/or emergency services; diagnostic procedures; transportation; nursing care; and other healthcare services provided to Recipient upon the instructions of Recipient's providers. Recipient acknowledges that no guarantees have been made regarding the outcome of these services. If Recipient is unable to sign, consent for treatment: (1) is hereby given by representative(s) authorized to make decisions and sign this agreement on Recipient's behalf, or (2) in cases of emergency, shall be implied. The term "**KIC THC** " includes the health care service providers owned or controlled by Ketchikan Indian Corporation Tribal Health Clinic.

Fraud Statement Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty for each violation

____ __________________
(Signature of Applicant) (Date)

____
(Signature of Legal Representative, if other than Applicant)

____
(Printed name)



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Residency Documents List

(One of these items must be at least 6 months old)

- ☐ State of Alaska Driver's License
- ☐ State of Alaska Identification Card
- ☐ Rental Receipt or Lease Agreement
- ☐ Bill from KPU with your Name and Address on it
- ☐ A single piece of Mail that has your Street Address Showing Residency
- ☐ Alaska Voter's Card
- ☐ State of Alaska Fishing Hunting or Trapping License
- ☐ A Notarized Letter showing Residency (Letter can be found at Patient Access on 2nd floor or 201 Stedman Behavioral Health Patient Access)
- ☐ Bank Statement (Name and Address is only needed - Not Financial Information)
- ☐ Alaska Permanent Fund Application (Proof of Filing)
- ☐ Pay Check showing pay period worked
- ☐ Alaska Medicaid / Denali Kid Care Approval or Denial Letter
- ☐ Plane or Ferry Ticket showing when you arrived to Ketchikan
- ☐ Cable Bill
- ☐ Ketchikan Senior Tax Free I.D. Card
- ☐ Military Transfer Orders

KIC Tribal Health Clinic

INSURANCE INFORMATION

Medical, Dental, Vision/Optometry, Pharmacy

Patient

Patient's name____Patient chart #__________________

Address____Telephone #___________________

Policy Holder

Policy Holder Name____Female______Male_______

Policy Holder Date of Birth________________________Policy Holder SS#____________________

Policy Holder Address____

Policy Holder's Status: Single___________Married___________Other ________________________

Insurance

Circle all that apply: Medical Dental Vision/Optometry Pharmacy

Name of insurance company____

Insurance company address____

_______ ____

Telephone Number of insurance company__________________________Effective date ____________

____

Group Name Group Number Policy ID Number

Employer's name/address/telephone number that provides healthcare coverage:

____

Name Address

____

City State Zip Telephone #

Dependents

Names of all persons covered by this insurance:

Name	Relationship to Policy Holder	Chart #	Date of Birth
________________________	__________________	____________	____________
________________________	__________________	____________	____________
________________________	__________________	____________	____________