



Wichita and Affiliated Tribal Member Health Plan

IMPORTANT NOTICE- ACTION REQUESTED

Enrollment Form required for all enrolled Wichita and Affiliated Tribal Members

IMPORTANT- PLEASE READ

* Please only fill this out for enrolled Wichita and Affiliated Tribal Members
(one for each tribal member)

Member Information (please print clearly) * = Required Field Please Complete

| | | | |
|----------------|--------------|---------|-----------------|
| *Last Name: | *First Name: | *MI: | *Date of Birth: |
| *Address: | *City: | *State: | *Zip: *SSN: |
| *Phone Number: | *Email: | | |

Are you a Veteran?

| | |
|-----|----|
| YES | NO |
| | |

Indicate type of other insurance coverage (check all boxes that apply)

| Medicare | Medicaid | SoonerCare | Veteran | Private Insurance |
|----------|----------|------------|---------|-------------------|
| | | | | |

The Statements made above are true and correct to the best of my knowledge I give my permission to use my information for our tribal member health plan, RWI Native Care Health to obtain any necessary medical records for insurance payment purposes only, to include or non-deferred referral from the Indian Health Service facility. I certify the statements above are true and correct to the best of my belief. I hereby authorize any insurance company, prepayment organization, employer, plan trustee or their designee, hospital or other health care provider to furnish any information with respect to myself or any of my dependents which may have a bearing on the benefits payable by this or any other plan providing benefits or services. A photo static copy of this authorization will be considered as effective and as valid as the original. This authorization will remain in effect until such time that I revoke it in writing.

*Signature: _____ *Date: _____
(Parent or Guardian if Member is under the age of 18 years)

HIPAA Privacy Statement

Your privacy is important to us. The information contained here will only be used for the purpose of this plan. For more information or questions regarding your health care plan, please call Native Care Health at 1-877-810-4587

Mail or Hand Deliver to:
Wichita and Affiliated Tribal Health Building
Attn:Lindsay Messer/Benefits Coordinator
PO Box 729
Anadarko, OK 73005

