WICHITA AND AFFILIATED TRIBES

Tribal Member Health Plan

HEALTHCARE CLAIM FORM

Please complete all items below and attach receipts that indicate the provider name and the amount you paid to the provider.

PATIENT/MEMBER DATA:

Tribal Member Name: Last, First, Middle (please print) Date of birth

Home Address: Street or PO Box # City State Zip

HIPAA Privacy Notice
Your privacy is important to us. Native Care Health (NCH) complies fully with all federal and state privacy protection laws and regulations.

IMPORTANT (Please read):
If you are covered through another insurance policy, please include a copy of the Explanation of the Benefits you received from your insurance company related to these healthcare services.

_____ _____

Your Signature Date

Mail to:
Native Care Health, LLC
PO Box 50
Quapaw, OK 74363

877-810-4587

OR

Scan this form and your receipts and email to sbankson@rwibenefits.com

NOTICE OF TIMELY FILING LIMIT: ALL CLAIMS FOR HEALTH, DENTAL, OR VISION SERVICES YOU RECEIVED IN A CALENDAR YEAR MUST BE FILED WITH NATIVE CARE HEALTH, LLC ON OR BEFORE MARCH 31ST OF THE FOLLOWING CALENDAR YEAR. CLAIMS RECEIVED AFTER MARCH 31ST ARE NOT ELIGIBLE FOR PAYMENT.