Sage Memorial Hospital
NAVAJO HEALTH FOUNDATION

Phone (928) 755-4898
Fax (928) 755-4758
Post Office Box 457
Ganado, Arizona 86505

PURCHASED/REFERRED CARE APPLICATION

PATIENT INFORMATION

Name: _____ MR# _____
(Last) (First) (M.I.) (Medical Record/Chart Number)

Address: _____ County: _____

Phys. Address: _____ Home Ph: _____

Date of Birth: _____ Marital Status: _____ Cell Number: _____

Tribe: _____ Census Number: _____

SPOUSE INFORMATION OR GUARDIAN/PARENT INFORMATION IF MINOR

Name: _____ MR# _____
(Last) (First) (M.I.) (Medical Record/Chart Number)

Address: _____ County: _____

Phys. Address: _____ Home Ph: _____

Date of Birth: _____ Marital Status: _____ Cell Number: _____

Tribe: _____ Census Number: _____

EMPLOYMENT INFORMATION / SCHOOL INFORMATION

Employer: _____ Phone: _____

Address: _____

School: _____ Grade/Level: _____

Address: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID#: _____

Policy Holder Name: _____ DOB: _____

Group #: _____ Insurance Phone Number: _____

Secondary Insurance: _____ ID#: _____

Policy Holder Name: _____ DOB: _____

Group #: _____ Insurance Phone Number: _____

Automobile Insurance (if involved in an accident)

Insurance Company: _____ Policy#: _____

Policy Holder Name: _____ DOB: _____

Relation to Patient: _____ Insurance Phone Number: _____

ADDITIONAL DEMOGRAPHICS

Is the Patient a Veteran? _____ YES _____ NO Branch of Service: _____

Is the Patient on SSI Benefits? _____ YES _____ NO

Is the Patient on ALTCS (Arizona Long Term Care) _____ YES _____NO

Case Worker Name: _____ Phone: _____

If Patient has Medicare, do they have Part _____A, _____ B, _____D, _____ Advantage Plan

Provide <u>one of the following</u> to show your current physical address

Valid State driver's license or State Issued ID card	Employment check stub received within the past thirty (30) days showing address and withholding taxes.	Utility Bill: electric, gas, water, cable, cell phone, or telephone issued within the last sixty (60) days.
Tribal ID card with a photo	Homeowner's or renter's insurance policy	Rental or lease agreement
U.S. Passport	Mortgage Statement	Rental payment receipt
Voter's registration card	Property Tax Bill	Settlement Papers
Valid college ID with a photo	Property Deed	Marriage License
Other Tribal government issued documents.		

LOCATION OF HOME (Draw Map)

PLEASE READ CAREFULLY:

I hereby affirm that the address listed on this form is my true and correct primary physical address. I further agree that it is my sole responsibility to inform the Purchased Referred Care Department immediately if my address changes. I understand and agree that I will not be eligible for Purchased Referred Care Services if I do not meet all requirements. I hereby authorize the Purchased Referred Care Specialist to contact other agencies to obtain information that is necessary to further enhance my eligibility, process referrals and claims. I also acknowledge that I have read the PRC patient requirements and responsibilities and agree to abide by them. I understand that false and misleading information in my application will result in denial of benefits

APPLICANT SIGNATURE: _____ **Date:** _____