**FORT BELKNAP CENTRALIZED BILLING DEPARTMENT**

**MEDICAID TRANSPORTATION ASSISTANCE PROGRAM**

**656 AGENCY MAIN STREET, HARLEM MT 59526**

**PHONE: 406.353.8341 FAX: 406.353.2884**
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Client Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medicaid #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian of minor child/ren: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Place of employment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**\*\*PLEASE ATTACH APPOINTMENT SLIP WITH THIS REQUEST\*\***

Appointment Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Appointment Time: \_\_\_\_\_\_\_\_\_\_\_\_\_

 Reason for appointment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Provider name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Hospital location: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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***This information is true and correct to the best of my knowledge. If I fail to make this appointment, fail to bring in my receipts for gas/lodging, or if I am employed, I agree that I will reimburse the funds I have been given to the Fort Belknap 3rd Party Billing Program. I will also have to call the State Medicaid office to obtain appointment reimbursement until the balance is paid in full.***

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



**FORT BELKNAP MEDICAL ASSISTANCE PROGRAM**

**RELEASE OF INFORMATION**

**\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\*\***

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have requested medical travel assistance from the Fort Belknap Medicaid/Centralized Billing Program.

I understand that any information I have given on my application maybe verified/investigated as allowed by Law or Presidential Order.

I also give my consent to the Release of Information concerning my health information such as:

* Referring Physician
* Receiving Physician
* Appointment dates/times
* Medical condition/procedures
* Medical Treatment Plans

I understand that this information will be kept confidential within the office and is protected under Privacy & HIPAA Laws.

I certify to the best of my knowledge and belief, all of the statements made on my application are true, correct, complete, and made in good faith.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_