GTB Purchased Referred Care
No Change Form

Grand Traverse Band of
Ottawa and Chippewa Indians
2605 N. West Bay Shore Drive
Peshawbestown, MI 49682
(231) 534-7223-PRC

PRIMARY TRIBAL MEMBER INFORMATION

Last Name _____ First Name _____ Middle_____

Social Security Number _____ Date of Birth _____ Tribal Enrollment # _____

Physical Address _____ City: _____ State: _____ Zip_____ Phone

Number:_____ Sex: Male _____ Female _____

Dependents & Birthdates:

I certify that all statements are true and complete to the best of my knowledge. And there is no changes in my address or insurance coverage for myself or my family

***Signature of Tribal Member _____ Date_____

PRC Member ID:_____ **Effective Date: _____** **FY_____** **HRN#_____**

AUTHORIZATION TO DISCUSS MEDICAL SERVICES WITH DESIGNATED PERSONS

I, (APPLICANT) _____HEREBY AUTHORIZE THE RELEASE OF INFORMATION REGARDING MY HEALTHCARE AND BILLING TO THE **GRAND TRAVERSE BAND OF OTTAWA AND CHIPPEWA INDIANS PURCHASED/REFERRED CARE**.

GTB PRC Staff: PRC@GTB-NSN.GOV
NAME(S)
2605 N. West Bay Shore Dr. Peshawbestown, MI 49682
ADDRESS (IF DIFFERENT)
231-534-7223-PRC HOTLINE
PHONE NUMBER

MY SIGNATURE PROVES THAT I HAVE READ THIS FORM OR HAD IT READ TO ME AND EXPLAINED TO ME IN A LANGUAGE THAT I UNDERSTAND. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT, IN WRITING, AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS ALREADY BEEN TAKEN. THIS CONSENT WILL EXPIRE 1 (ONE) YEAR FROM THE DATE SIGNED OR IMMEDIATELY UPON RECEIPT OF WRITTEN REQUEST TO REVOKE.

APPLICANT'S SIGNATURE:_____DATE:_____

VERIFICATION OF RECEIPT OF PURCHASED/REFERRED CARE INFORMATION

_____ I HAVE RECEIVED THE PURCHASED/REFERRED CARE (PRC) INFORMATION. I WILL REVIEW IT AND
INITIALS IF I HAVE ANY QUESTIONS, I WILL CONTACT THE PURCHASED/REFERRED CARE ELIGIBILTY SPECIALIST.

VERIFICATION OF YEARLY UPDATE & CHANGE IN CONTACT INFORMATION

_____ I UNDERSTAND THAT MY PRC FILE **MUST** BE UPDATED ONCE A YEAR DURING THE MONTH OCTOBER. I ALSO UNDERSTAND THAT FAILURE
INITIALS TO UPDATE AND REPORT ANY CHANGES IN MY ADDRESS, NAME, PHONE NUMBER / CONTACT INFORMATION, OR MEDICAL COVERAGE(S) COULD RESULT IN SUSPENSION OF MY BENEFITS THROUGH GTB PURCHASE/REFERRED CARE.

WITH MY INITIALS ABOVE AND MY SIGNATURE BELOW I AGREE THAT I HAVE RECEIVED THE PURCHASED/REFERRED CARE INFORMATION. I ALSO KNOW THAT I **MUST** UPDATE MY FILE ONCE EVERY YEAR DURING THE MONTH OF OCTOBER.

APPLICANT'S SIGNATURE:_____DATE:_____