

**GTB Purchased/Referred Care Update**

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



**Section 1 PRIMARY TRIBAL MEMBER INFORMATION**

Last Name X \_\_\_\_\_ First Name X \_\_\_\_\_ Middle X \_\_\_\_\_

Social Security Number X \_\_\_\_\_ Date of Birth X \_\_\_\_\_ Tribal Enrollment # X \_\_\_\_\_

Physical Address: X \_\_\_\_\_ Mailing Address: X \_\_\_\_\_

City: X \_\_\_\_\_ State: X \_\_\_\_\_ Zip X \_\_\_\_\_ Phone Number: X \_\_\_\_\_ Sex: X Male \_\_\_\_\_ Female \_\_\_\_\_

X Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Date of Marriage: \_\_\_\_\_ Date of Divorce: \_\_\_\_\_

**Section 2 Tribal Member's Family Information**

Name of Tribal Members	Relationship	Date of Birth	Tribe/Enroll # (if applicable)	Sex	Social Security #	Address (if different from above)	Current Insurance
X							

PRC Member ID: \_\_\_\_\_ Effective Date: \_\_\_\_\_ FY \_\_\_\_\_ HRN# \_\_\_\_\_

**Section 3 Insurance Information**

Name of Tribal Members	Current Insurance Coverage	Insurance Numbers	Effective Dates	Medical	Dental	Vision	Prescription Drugs
X	X	X	X	X	X	X	X

I certify that all statements are true and complete to the best of my knowledge. I authorize any physician, medical facility, employer, having information as to employment, medical coverage, or medical care, for my spouse, dependent children and myself to give such information to GTB Purchased Referred Care or its administrators to determine Eligibility for coverage. GTB Purchased Referred Care is a payer of last resort. I agree that the company may release such information to its representatives or re-insurers or as permitted by law. I also understand that if I or any members listed on this application use the GTB Family Health Clinic we may also be eligible for services under the Medical Relief Block Grant.

\*\*\*Signature of Tribal Member   X   \_\_\_\_\_ Date X \_\_\_\_\_

**AUTHORIZATION TO DISCUSS MEDICAL SERVICES WITH DESIGNATED PERSONS**

I, (APPLICANT) X \_\_\_\_\_ 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: X \_\_\_\_\_ DATE: X \_\_\_\_\_

**VERIFICATION OF RECEIPT OF PURCHASED REFERRED CARE INFORMATION**

X \_\_\_\_\_ 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 ELIGIBILITY SPECIALIST.

**VERIFICATION OF YEARLY UPDATE & CHANGE IN CONTACT INFORMATION**

X \_\_\_\_\_ 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: X \_\_\_\_\_ DATE: X \_\_\_\_\_

**PURCHASED/REFERRED CARE (PRC)  
AUTHORIZATION INFORMATION**

You must obtain authorization from PRC at least **2 days/48 hours before your scheduled appointment**. Any appointments called into PRC the day of will result in you either rescheduling or be responsible for any charge incurred on that day.

**X-rays and Lab Work will be same day approval.**

**Authorization for Emergency Room/Urgent Care Visit:**

\*Notify PRC within 3 days/72 hours of onset of illness/accident.

\*Elders & persons with disabilities have up to 30 days to notify PRC of illness/accident.

\*When needing to go to Urgent care you are to use the MCHC Urgent Care at 550 Munson Ave in Traverse City. Only use the Main Munson Medical Center for Emergency life threatening situations.

**PURCHASED/REFERRED CARE APPOINTMENT HOTLINE—231-534-7223**

Use this number to call in any appointments you have or will have. Appointments must be called in 48 hours in advance. The hotline is checked daily for the processing of authorizations for eligible PRC clients.

**Authorization for Prescriptions:**

Must use the following Pharmacies:

GTB PHARMACY 231-534-7350

- **New PRC Clients** – will be able to get prescription the next business day after signing up for PRC unless you need to get prescription the same day. **EMERGENCY ONLY!**

**PRC Priority Levels of Care**

PRC payment is limited by priorities. Priority Levels of Care are posted at the clinic, PRC office and GTB Government buildings. Therefore, some treatments and procedures may be deferred based on levels of funding. PRC is not an entitlement program and cannot guarantee payment.

For any PRC questions you may have, please do not hesitate to EMAIL OR CALL: PRC@GTB-NSN.GOV OR 231-534-7223

Client Print Name: \_\_\_\_\_ Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

PRC Staff Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Cc:file