NOTTAWASEPPI HURON BAND OF THE POTAWATOMI
A FEDERALLY RECOGNIZED TRIBAL GOVERNMENT

Nottawaseppi Huron Band of the Potawatomi
Health Program Application

Group: NHBP

Forest County Potawatomi
PO Box 370 5415 Everybody's Rd
Crandon, WI. 54520-0370
(715)478-7448

Section 1 Tribal Member Information

Effective Date:_____

Last Name: _____ First Name: _____Middle:_____

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

Physical Address:_____ Mailing Address:_____

City:_____ State: _____ Zip:_____ Phone Number:_____Sex: Male ◯ Female ◯

Marital Status: Single ◯ Married ◯ Divorced ◯ Widowed ◯ Date of Marriage: _____ Date of Divorce: _____

Section 2 Family Household Information

Spouse/Dependent Name	Relationship	Date of Birth	Tribe/Enroll# (if applicable)	Sex	Social Security #	Address (if different from above)	Office Use Only File #

Section 3 Other Medical Insurance Information

Are you or any of your household members covered under?: State Medical Program ☐ Medicare ☐ Champus ☐ Other medical plan ☐

If yes, please provide the name of the covered household members in the table below.

Which benefits does the other insurance plan provide?: Medical ____ Dental ____ Vision ____ Prescription Drugs ____

Section 4 Coordination of Benefits Information

Self/Spouse/ Dependent Name	Other Insurance? Yes/No	Name and Address of Other Insurance	Phone Number of Insurance Company	Insured's ID#	Insured's Group #

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 Nottawaseppi Huron Band of the Potawatomi Tribal Member Health Program or its administrators to determine eligibility for coverage. Nottawaseppi Huron Band of the Potawatomi Tribal Member Health Program 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.

***Signature of Tribal Member _____ Date _____

For Office Use Only:
Approved Signature: _____ Date:_____ Processed: _____