

Prescription Information: [original signed prescription(s) must be attached]

Dear Doctor: Your patient has requested medication provided through a tribal benefit of the Chickasaw Nation. In order for him/her to receive his/her prescriptions we require some information before determining if this can be provided by our program. Please complete the following. The patient will be notified if the prescription can be filled prior to it being processed. Allow sufficient time for dispensing and mailing.

Medication List:

	DRUG ALLERGIES:

Physician Information:

Printed name: _____
Address: _____ City: _____ State: _____ Zip code: _____
Phone (____) ____-____ Fax (____) ____-____
Specialty: _____
State license no.: _____ State of _____ DEA no.: _____
NPI no.: _____

On behalf of my patient, _____, I request the above medication be provided through the Chickasaw Nation Tribal Health Program. I certify that the patient is under my care at this time and will be followed appropriately. The medication prescribed for my patient is in accordance with the scope of covered drugs (*see below*) available under this program. I agree to provide additional information necessary to process claims to Medicare or private insurance on behalf of my patient. I further state that I am licensed to practice medicine in the indicated state above with evidence of active participating privileges in state and federal programs.

Signature of provider: _____ Date: _____

Non-covered drugs:

- Anti-rejection
- Chemotherapy
- Compounded substances
- Controlled substances
- Investigational
- IV Medications/devices to administer drugs
- Over-the-counter
- Performance enhancing
- Short-term use

For Internal Use Only	
ID/Voucher # _____	Acceptance notice mailed _____

Coordinator name: _____