



*This Form will be filled out with NIS staff assistance, if needed; and will aide in ensuring that appropriate follow-up will be conducted in relation to health care access*

**MILLE LACS BAND OF OJIBWE INDIANS**

**Health & Human Services Division**

Circle of Health Program

Clinic Referral Form

Name: \_\_\_\_\_

Date:

Band ID: \_\_\_\_\_

Active Phone Number:

If a Band member has previously filled out enrollment or consent forms, please use this form only.

Please check all that apply:

Band Member

\_\_\_\_\_ has filled out Minnesota Health Care Program applications

\_\_\_\_\_ has lost state coverage and date \_\_\_\_\_

\_\_\_\_\_ distributed Circle of Health Private Insurance Application

\_\_\_\_\_ has no insurance, distributed Private Insurance Checklist

\_\_\_\_\_ requests Circle of Health to mail Brokers National Life Ins for Dental/Vision coverage to be effective the first of the following month, forms also at Dental Clinic

\_\_\_\_\_ has been informed of Benefit Coordinator schedule of Monday's

\_\_\_\_\_ denied by IHS and reason

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Completed by

Title

Date