

ATTACHMENT A

CENTRAL VALLEY INDIAN HEALTH, INC.
20 NORTH DEWITT
CLOVIS, CA 93612
(559) 299-2578

**PATIENT REQUIREMENT FOR
ALTERNATE RESOURCE DETERMINATION**

DATE: _____ DATE OF BIRTH: _____

PATIENT NAME: _____

ADDRESS: _____ CITY/STATE/ZIP: _____

HM. PHONE: _____ CELL: _____

This information is necessary pursuant to Indian Health Service Regulations, 42 CFR, Subpart G, Paragraph C. You must provide this facility with a copy of the alternate resource's eligibility determination.

PLEASE CHECK THE LINE THAT PERTAINS TO YOU THE PATIENT:

YES _____ NO _____ Do you have Medi-Cal?

YES _____ NO _____ Do you have Medicare?

YES _____ NO _____ Do you have private health insurance, including Kaiser Insurance?

YES _____ NO _____ Do you have CMSP from Fresno, Madera or Kings County?

If you answered **YES** to any of the above questions, please give your card to the Medical Receptionist to copy for your file.

If you answered **NO** to all of the above questions, you will need to be screened by the Patient Services Representative at 299-2608, ext. 174. You can also apply at the Social Services Office in the county you reside.

If you are employed, we need a statement from your employer stating that you do not have medical insurance.

If you need assistance, please contact the CVIH Patient Services Representative.

You will have 60 days to complete the necessary information and return it to the CHS/Eligibility Office. If no information is returned, and there is no request for assistance, a CHS denial letter will be issued.

Sincerely,

CENTRAL VALLEY INDIAN HEALTH

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|------------------------------|-------------|
| FOR OFFICE USE ONLY | |
| _____ | |
| PATIENT SERVICES REP. | DATE |