



**GRANTS AND DONATIONS DEPARTMENT**

MANDAN, HIDATSA, ARIKARA NATION

LOCATED AT: CHRC 3<sup>RD</sup> FLOOR (1293 ELBOWOODS LOOP)

MAILING ADDRESS: 307 5TH AVE.

NEW TOWN, ND 58763

OFFICE: (701) 627-4863 FAX: (701) 627-4868

**Optometric Cataracts Assistance Request Application**

**TYPES OF ASSISTANCE:**

\_\_\_\_\_ **Cataracts Lifetime Maximum amount allowable is up to (\$1,500.00 per eye) per enrolled member.**

**Must Provide: (listed below)**

- Treatment Plan
- W-9 Form (From Vendor/Provider.)

**\*Must utilize Private Insurance, IHS, Medicaid, Medicare, etc. First\***

**Please Print Legibly (Client Receiving Care)**

Legal Full Name (First, Middle, Last)	Enrollment Number	DOB
_____	301U-_____	_____

Contact Number(s) (\_\_\_\_)\_\_\_\_\_ or (\_\_\_\_)\_\_\_\_\_

Medical Insurance:	ID #
_____	_____

**Optometric Provider:**

\_\_\_\_\_ Contact Number (\_\_\_\_)\_\_\_\_\_

**Have you received Cataract Assistance through any Tribal Program before? Yes  No  If yes, which Program? \_\_\_\_\_ Left or Right Eye or Both? \_\_\_\_\_**

**FOR OFFICE USE ONLY**

Amount Approved: \$ \_\_\_\_\_ Approved By: \_\_\_\_\_ Date \_\_\_\_\_

Left Eye \$ \_\_\_\_\_  Cataract Services

Right Eye \$ \_\_\_\_\_  Lens Upgrade

**\*\*Please Note Approval Process May Take Up to 2 Weeks\*\***

*"The Tribal Business Council of the Three Affiliated Tribes hereby embraces a philosophy of care for our sickest, most vulnerable critically ill patients, and promises the patient's clinical condition as priority."*