KLETSEL DEHE WINTUN NATION
HEALTHCARE ASSISTANCE FORM
PROGRAM GUIDANCE SHEET

PROGRAM OVERVIEW AND REQUIREMENTS

The following Items listed below are prohibited or regulated pursuant to the Nation's Healthcare Policy of June 17, 2022, adopted by Tribal Council *Resolution No. 06-17-2022-A on June 17, 2022*

- **The costs incurred must be from January 1st, 2024, to December 31st, 2024.**

- **If you are a patient of NVIH and reside in the City of Red Bluff CA, Counties of Glenn, Butte, Colusa, & Yolo in CA, and are PRC Eligible you must present your reimbursement/expense request to the PRC department at NVIH first.**

A. Required documentation such as receipts of expense and the expense must clearly identify as being an expense that the tribal citizen has incurred to be considered for program coverage.

Examples:

a. RX Customer Copy

b. Receipts of payment

B. Medically prescribed marijuana in any form is prohibited from coverage.

C. Medically prescribed opioids for any purpose are prohibited from coverage.

D. Non-medically necessary cosmetic procedures.

E. Any single medical expense greater than $10,000 shall require Tribal Council authorization before payment is issued.

F. Payments authorized under these procedures shall allow for at least five (5) business days to be executed.

G. All incomplete applications will be denied and returned, with detail as to why it was denied.

Completed applications must be emailed to: info@kdwn.org
Faxed to: (530) 387 3109
Mailed to: P.O. Box 1630, Williams CA 95987

For program questions contact the tribal office at: 530 419 5058

KLETSEL DEHE WINTUN NATION

Tribal Healthcare Expense/Reimbursement Form 2024

Tribal Citizen (Printed) Name: _____

Physical Address: _____

Current Mailing Address: _____

(City)_____(State)_____(Zip)_____

Phone Number:_____ Email Address: _____

(Select the box below that best fits your request)

I am requesting funding assistance for: ☐ **Expense** ☐ **Reimbursement**

Are you a patient of NVIH? ☐ No ☐ Yes If yes, which service below?

☐ **Dental** ☐ **Medical** ☐ **Behavioral** ☐ **Other**:_____(Please describe)

(Check the category of the expense and attach proof of expense along with this form.)

☐ **Co-pays for Procedures, Visits, Private Insurance:** **$**_____

☐ **Prescription Costs:** *"Dr. Prescribed Medications / NOTE: Opioids Prohibited"* **$**_____

☐ **Eyewear/Glasses:** **$**_____

☐ **Orthopedics:** *"Lower limb/feet specialists***"** **$**_____

☐ **Physical Therapy:** **$**_____

☐ **Orthodontics/Oral-surgery: "***Dentures/Partials/Braces/Wisdom Teeth"* **$**_____

☐ **Behavioral Health:** **$**_____

☐ **Other Non-Cosmetic Health Provider Services:** **$**_____

(Applications listing "Other" may be subject to additional review by the Tribal Council before approval)

Total amount of request: **$**_____

Payable To: _____

Address To Mail To: _____

_____ _____

Tribal Citizen Signature Date

STAFF ONLY:		Eligible? - If no, why? ☐ Yes ☐ No
_____ Admin Authorization	_____ Date	☐ Insufficient Documentation Cured? ☐ Yes Date:_____
_____ Fiscal Authorization	_____ Date	☐ Ineligible Cost ☐ Not 2022 Expense Pmt. Notice Date Date:_____ ☐ Email ☐ Call