Indian Health Service
Little Shell Tribe
Purchased/Referred Care
Request for Services Form

Fax form to: 406-247-7232

Date of request: _____ **PRC Staff name:_____**

RCIS #_____

Name:_____ **Chart:_____**

SSN:_____ **DOB:_____**

Father/Mother:_____ **Phone #_____**

Address:_____

_____

Provider:_____

Provider Address:_____

Provider Phone #_____

Provider EIN:_____ **Provider name:_____**

Date of Service:_____ **Inpatient/Outpatient:_____**

DRG:_____ **Discharge date:_____**

Diagnosis:_____

Comments:_____

_____

Referral:_____ **Referring Physician:_____**

Medicaid #_____ **Medicare #_____**

Private Insurance:_____

Tribe:_____ **Enrollment #_____**

Employer:_____