New York State Department of Health
American Indian Health Program
Pharmaceutical and Vision Care Enrollment Form

This form is to be completed for coverage in the American Indian Health Program prescription drug or vision care benefits plan.
The personal information you provide on this form is confidential, and will be used only to provide you with these services.

Complete one form for each family member living in the household. **Please Print**

Please check the coverage for which you are enrolling

☐ **Pharmaceutical (Prescription)** ☐ **Vision Care**

☐ New ☐ Replacement ☐ Change Information

Last Name First Sex ☐ Male ☐ Female

Date of Birth: ☐☐ ☐☐ ☐☐☐☐
Month Day Year

Street Address Apt #

City State Zip ( ) Telephone

Mailing address if different:

Street Address Apt #

City State Zip

Are you covered jointly or as a dependent in another insurance plan that covers prescriptions or vision care?

☐ YES ☐ NO

If yes, fill in the following information:

Name of insured person Relationship

Insurance Plan Name: Group # Policy #

Do you receive benefits from the NY State Medicaid Program? ☐ YES ☐ NO

Medicaid ID #: _____

I understand that false statements may result in cancellation of coverage to card holder.

Your Signature: _____ Date: _____
(Enrollee or Guardian)

For Nation Use Only

☐ Tonawanda Seneca ☐ Tuscarora ☐ Oneida ☐ Onondaga

☐ Unkechaug ☐ Shinnecock

Eligibility approval by Nation clerk or authorized representative:

SIGNATURE PRINTED NAME

Tribal Enrollment Officer
Title

For DOH Use Only

Enrollment Date: _____ ID# _____ Initial: _____