Understanding Peter Christensen Health Center's Contract Health Services Program

(Handbook for our Patients)

Step 1 Introduction:

What is Contract Health Services?

Peter Christensen Health Center is a Native American operated healthcare facility of the Lac du Flambeau Band of Lake Superior Tribe. Our facility is located in the northern part of Wisconsin and part of the Bemidji area Indian Health Services.

PCHC provides healthcare services that range from outpatient, optometry, and other services that promote wellness. There are, however, some areas of health services that we cannot provide direct care to beneficiaries at our facility. In addition, there are specialized medical procedures that are routinely referred to other facilities that are not part of PCHC. In order for PCHC to pay for those services, it is important that you understand your role in accessing what is called "Contract Health Services."

Funds are limited to pay for Contract Health Services, and guidelines in which Congress and Indian Health Service have put in place must be enforced. These guidelines define patients who are eligible for services and what costs are covered. If guidelines are not followed, federal regulations prevent PCHC from paying for your care.

This booklet is designed to help you understand those guidelines and your responsibilities. Thank you for taking the time to read through this handbook. We recommend you keep it handy and refer to it if you have any questions about Contract Health Services.

Step 2
Please Call Us!!

The most important thing for you to know:
Call Us!

Referral Coordinator
(715) 588-3371 Ext. 1255
Benefits Coordinator
(715) 588-3371 Ext. 1250,

The first and perhaps the most important thing for you to understand about Contract Health Services is how important it is for you to call us if you have any questions BEFORE you receive services. Please call the numbers noted on this page to talk with our Contract Health Services employees to see if payment can be authorized for your care.

When you call, you can find out your eligibility and if the service you need is covered. Please don't wait until its too late! Call first and request authorization.

If you seek treatment for non-emergency services at a hospital or urgent care facilities, payment may be denied. An emergency is not defined by the location where the treatment was received and is limited to treatment.

Call First for Authorization
In order for Contract Health Services to authorize payment for medical care not available at PCHC, PCHC must first authorize your referral. If the healthcare service you receive is not an emergency, authorization is required prior to the service.

Emergency Calls (72-Hour Rule)
If the service your receive is an emergency, Contract Health Service must be notified within 72 hours of your emergency services. If you are 55 years of age or older and/or disabled, you have 30 days to notify Contract Health Service of your emergency care(§406 of P.L 94-437, as amended).

Examples of Emergencies:
Trouble breathing-/-Chest Pains -/- **Bad Burns -/- **Poisoning
**High Fever in infants, children or the elderly.
**Life-threatening accidents/injuries

Step 3
Eligibility

To be eligible for PCHC Contract Health Service Funds

1. American Indian and/or Alaskan Native - To be eligible for Contract Health Services funding, you must provide proof that you are a member, or descendent of a member, of a federally recognized tribe. (CFR), at Title 42, Section 136.21 through 136.25, and Indian Health Services, Part 2, Chapter 3, "Contract Health Services" dated January 5, 1998.

A. Documents accepted as proof of tribal membership or proof of Indian Blood includes:

- Certificate of Indian Blood (CIB) issued by the Bureau of Indian Affairs (BIA) or
- Certificate of Degree of Indian Blood (CDIB) issued by the Bureau of Indian Affairs, or
- Tribal enrollment card or letter of descendency issued by a federally recognized tribe.

What if I do not have one of these documents?

If you do not have the paperwork or issued card, contact your enrollment office.

Important Notes

- Individuals may be required to pay for services if PCHC determines that the patient is not eligible or if he/she fails to provide the paperwork that proves eligibility. **"NO"** patient will be denied any medical services.
- IHS requires that patients provide proof of eligibility within 90 days of its request and/or on the **next medical visit.**
- Patients are asked to show proof of eligibility before they will be scheduled for offsite Medical Referrals.

2. Non-Natives who are:

- Women pregnant with the child of an eligible American Indian or Alaska Native are eligible for prenatal care, delivery, and up to six weeks of post-partum care, or
- Adopted, step or foster children who are dependents of an eligible Native Parent or guardian may receive Contract Health Funding until the age of 18.

3. **Native beneficiaries,** who are requesting to prove eligibility, must present documents of residency to meet the guidelines of Contract Health Service Deliver Area (CHSDA). Three documents listed at the bottom of the page must be presented.

For those moving into the CHSDA, you must reside within the CHSDA for 3 months or 90 days before residency can be established to prevent any delay of your CHS medical care. You must notify the CHS within the first 5 days of re-entering the CHSDA to allow proper coordination of time factors. PLEASE NOTE: Per LDF #307(02), the LDF Tribal Council has waived this 90 day waiting period for LDF Tribal Members. You will need to complete a residency verification for this purpose.

Step 3 – Cont. Eligibility

If you move outside of the CHSDA, you only remain eligible for emergency medical services for **6 months/180 days** from the time of moving. You must have IHS eligibility on file with PCHC **prior to moving.** Those included for eligibility are the Lac du Flambeau tribal members moving outside of the area, other Indian persons who maintain "close social and economical ties" with the tribe; and transients (persons who are in travels or are temporarily employed, such as seasonal or migratory workers, during their absence).

Documentation for Proof of Eligibility Include:

- Birth Certificate
- Two months of rent or mortgage receipts
- Proof of residency form available at PCHC.
- Social Security Card
- Student Enrollment
- Employer pay stubs 60 days Residency/180 days moved
- Phone/Utility bill receipts for 60 days/180 days moved
- Driver's license or State ID dated: 60 days/180 days moved
- Primary Insurance Card (Private Insurance/Medicare/Medicaid)
- Application for alternative resources denial or approved letter from state
- Other documents may be accepted upon review

4. A. Payor of last resort requirements

A. Payor of Last Resort Title 42 CRF §136.61. The IHS is the payor of last resort for services provided to patients defined as eligible for CHS under these regulations, notwithstanding any State or local law or regulation to the contrary. Accordingly, the IHS is responsible for paying or authorizing payment for CHS if the AI/AN is a victim of a crime (see Section 2-3.24), unless:

1. The AI/AN is eligible for alternate resources, defined in Section 2-3.9G, or
2. The AI/AN would be eligible for the alternate resources if he or she were to apply for them, or
3. The AI/AN would be eligible for alternate resources under State or local law or regulation but for the Indian's eligibility for CHS or other health services, from the IHS or IHS programs.

B. **Eligibility.** The facility's CHS Department must first determine whether the patient applying for CHS funds is eligible pursuant to Title 42 CFR §136.12 and §136.23. In addition, the facility must determine that the medical services requested for payment from CHS funds are within medical priorities. The CHS program is not an entitlement program, therefore when funds are insufficient to provide the volume of CHS needed, priorities for service shall be determined on the basis of relative medical need (Title 42 CFR §136.23(e). Before authorizing payment with CHS funds for services received by an eligible AI/AN patient, must first:

1. determine, upon reasonable inquiry, whether the patient is potentially eligible for alternate resources.

2. Advise the patient of the need to apply for alternate resources.

3. Assist the patient in applying, especially where it is evident that the patient is unable to apply or is having difficulty with the application process.

C. **Completed Application to Alternate Resources Program.** The alternate resource program denies payment of the AI/AN patient's medical bills for a valid reason, such as the patient is over income eligibility standards or not a resident of the county and the AI/AN is otherwise CHS eligible, the Area/Service Unit should pay the AI/AN patient's medical bill. However, an AI/AN patient cannot be denied alternate resources because he/she is eligible for the IHS and CHS programs.

Step 3 – Cont.

Eligibility

D. **Failure to Follow Alternate Resource Procedures.** There are two instances when the IHS will not pay the provider for medical bills incurred by an otherwise CHS eligible patient:

1. When the patient willfully or intentionally fails to apply or fails to complete an alternate resource application. If the IHS does not require its patients or beneficiaries, in "good faith," to apply for and complete an alternate resource application, the alternate resource rule will have little effect on conserving contract health funds.

2. In 30 days, from the ER/Urgent care visit, the patient does not contact the CHS for assistance in completing the application, then a CHS denial will be issued. If an alternate resource program issues a denial because the applicant failed to apply or failed to complete the application and the CHS file documents all attempts to assist the applicant, the CHS office should issue a CHS letter of denial to the patient.

3. When the "outside facility" provider fails to follow alternate resource procedures, such as notifying the CHS program within specified time constraints, the IHS' trust responsibilities include a requirement that providers maximize the availability of alternate resources. Thus, if the provider is not able to receive payment from an alternate resource program because of the provider's failure to follow proper procedures, the IHS will not be responsible for the medical bill, even if the AI/AN patient is otherwise CHS eligible.

5. Have establish care with PCHC Primary Care Provider within the last 6 months.

Can I receive Contract Health Services funding if I haven't established eligibility?

NO. Contract health funds cannot be authorized until all these requirements have been met.

Step 4

Medical Referrals

What is the referral process?
If your PCHC provider feels you are in need of a referral to a specialist, they will begin the referral process. The referral must come from our PCHC Medical Provider. Each and every referral must be documented and/or submitted for preauthorization, thus receiving a confirmation/approval within a 7-day timeframe from our Managed Care Team.

The 7-day Timeframe
Referrals will be reviewed and submitted to the Managed Care Team within a 7-day timeframe. If your referral is documented on a Monday, Tuesday, or Wednesday prior to the meeting of the that week, the referral **will not** be submitted until the next designated meeting. This timeframe process will permit the following:

- Confirmation to determine if the patient meets the requirements of CHS 60-day/180-day rule and resides within the established service delivery area.
- Confirmation to determine if the patient has insurance, Medicare, Medicaid, or Private Insurance.
- If the patient does not have alternative resources, the patient will be required to meet with the PCHC Benefits Coordinator.
- If the patient chooses to opt out of the program, all costs will be the responsibility of the patient i.e., co-payments and overall cost of the designated visit.
- To utilize CHS funds he/she will be required to apply for any alternate resources that might be available if he/she is eligible.
- Yearly CHS Application/update.
- Patient must sign and date referral and take copy of the referral to the appointment.
- Patient must submit any and all bills, EOB's, claims, coordination of benefits, etc to the CHS department.

Step 5
Emergency Medical Care

Medically Necessary Services

It is extremely important that Emergency Rooms are for **"TRUE"** emergencies and not for care that could be performed at PCHC.

For emergency treatment, urgent care or admission to a non-IHS facility, the patient or patient's representative must notify the PCHC Contract Health Department within 72 hours of the emergency services. If you are **55 years of age or older and/or disabled,** you have 30 days to notify Contract Health Services of your emergency care **(§406 of P.L 94-437, as amended)**.

Special Notice: 72-hour notification for Emergency Room does not guarantee payment. All ER/urgent care services will be reviewed by the Managed Care Team to determine the medical necessity of service for approval and/or denial of your medical claim.

Reminder of Insurance (Bring all insurance cards).

Emergency Room Prescription (s) Coverage

All emergency/urgent care prescriptions will be approved/denied by the PCHC pharmacy and/or the PCHC Managed Care Team.

Emergency Room Requested Follow-up Visit (s)

If the Emergency Room provider requests you to follow up, it must be with a primary care provider. If PCHC Contract Health Service is not notified within 72 hours of any treatment, procedures and/or specialized service, your medical bill will be denied. Any no show of the follow up with your provider at PCHC will deny your ER/UV also. These actions could ultimately affect you economically and affect your credit status.

Example of Emergencies

- Trouble Breathing
- Chest Pain
- Bad Burns
- Poisoning
- Broken Bones
- High Fever for Infants, Children or Elderly
- Life-threatening Accidents and/or Injuries

Contract Health vs. Auto Accidents

Not only do you need to notify PCHC Contract Health Service within 72-hours for all Emergency Room visits, but if you are involved in an automobile accident, your claim will be placed on ***hold-pending status*** waiting for the outcome of your legal claim and/or status of your automobile accident.

Since the state of Wisconsin law (started June 1, 2010) requires that individuals have automobile insurance, Contract Health will not pay for injuries related to auto accidents until insurance has been maxed.

- Please Note: PCHC-Contract Health is always the payer of last resort.

CHS will request the following from you:

- Auto Insurance Policy Number
- Signature of Peter Christensen Health Center's 3rd Party Liability Form.
- Legal Counsel Name and Office Telephone number for legal claim, if any.

Step 5 – Cont.
Emergency Medical Care

Contract Health vs. Workman's Comp

If you are involved in a work related injury, your claim will be placed on ***hold-pending status*** waiting for the outcome of your legal claim and/or status of your Workman's Compensation Claim.
All employers are required to provide worker's compensation insurance, and Contract Health will not cover job-related injuries. It is **extremely important** that you notify your employer immediately of your injury no matter how slight. You need to comply with your employer's guidelines no matter how small your claim, otherwise, you **may be denied to non-compliance** toward your employer's compensation plan. This could adversely affect you economically and your future credit status.

CHS may request the following from you:

- 1st report for work related injury
- Workman's Compensation Insurance Policy Number
- Legal Counsel Name and Office Telephone Number for legal claim, if any.

Ambulance or Air Flight for life Transport

Ambulance Service is provided for immediate emergency care and transport to Howard Young Medical Center in Woodruff, Wisconsin for emergent treatment. The Ambulance Service is under the standards and guidelines through the Emergency Department with Howard Young Medical Center.
In cases of **immediate life-threatening circumstances,** the Ambulance Service or HYMC will call Air Life-Flight for transport or emergent medical treatment.

Reminder: 72-hr notice is required for all emergent or urgent care services.

Will I be covered for emergency care while I am temporarily traveling outside the Lac du Flambeau Indian Reservation?

YES, you must notify PCHC Contract Health Service in Lac du Flambeau within 72 hours - including weekends and holidays (leave voicemail on weekends and holidays) at (715) 588-3371 after the emergency room medical treatment. If you are too sick and disabled, a relative, friend or healthcare provider can notify Contract Health Services on your behalf. ***However, the notification is your ultimate responsibility.***

CHS medical coverage is provided for:

- LDF Tribal Members moving outside of the Lac du Flambeau Reservation (CHSDA); 180-day maximum departure for emergent services.
- LDF-180 days (including 1st descent)
- Non LDF/other - 30 days

When You Get the Bill for Emergency Room Services?

1. **Check the bill.** Make sure you are not charged for services or medications you did not receive.
2. If there is an error on your emergency room bill, **write to your insurance company.** We can try to help you or contact the hospital with the discrepancies with your information.
3. Make sure insurance was billed.
4. If your insurance company refuses to pay for the emergency room services or medications you received, don't be afraid to **file an appeal.**
5. Bring your Urgent Care or ER bill to the PCHC-Contract Health Department as soon as you receive it.

Step 6
Specialty Services (Mammogram's)

The PCHC Mammogram Program

The PCHC's Mammogram Program shall be made available and we shall encourage all women of the Lac du Flambeau Tribe and/or Native American patients that meet the CHS guidelines to utilize the valued program. It will also be the responsibility of the patient to actively participate in the financial assistance through - Wis. Well Woman's Program (WWWP) .

Each eligible tribal member without insurance will be covered 100% of the cost for your mobile mammogram. If you have insurance PCHC will pick up the balance after your insurance, only after alternate resources have been determined.

What is the process for the mammogram program?

Women wanting to be scheduled for the mammogram program should do the following:

- Contact the PCHC appointment/scheduling coordinators to request an appointment with one of your PCHC providers, to be examined and request a referral for your mammogram.
- Our medical providers will conduct a medical review, plan a care and make a referral to the PCHC Mammogram Program.
- If the patient does not have alternative resources, the patient will be required to meet with the PCHC Benefits Coordinator or the PCHC-WWWP Site Coordinator.
- If the patient refuses to apply to for alternate resources, all costs will be the responsibility of the patient i.e., co-payments and overall cost of the designated visit.

Step 7
Student Health Program

What is the student program process and coverage?

Students must provide the Peter Christensen Health Center's Contract Health Care Services with their school schedule at the start of each **semester:**

- All Contract Health Eligibility Guidelines still apply.

Who is eligible for the PCHC Student Contract Health Care Service Program?

PCHC patients, spouses (if applicable) and/or legal dependents who temporarily leave their permanent place of residence for the sole purpose of attending programs of vocational, technical or academic study on a full-time basis.

Important note: Routine medical needs are to be taken care of before leaving the Lac du Flambeau Indian Reservation/Peter Christensen Health Center. Routine care includes school physicals, annual exams, immunizations, vision examinations, birth control, etc.

Step 8
Denials and Appeal Process

What is a Denial and Appeal of Services?

A denial and appeal means that a claim submitted to CHS was denied for payment, an appeal is your request for payment of service which has been denied by the PCHC Managed Care/CHS program.

You must write an appeal for your denial, including your DOS to the PCHC Health Director;

What is the process for the Denial and Appeal?

Each and every referral will be given a complete review, research and requested approval if applicable and compliant under the payer of the last resort regulations.

The regulation states: The IHS "will not be responsible for or authorize payment for Contract Health Services to the extent that the Indian is eligible for alternate resources… or the Indian would be eligible for alternate resources **were they to apply for them**."

DENIED VISITS: If the Managed Care Committee has denied your requested referral or medical bill, you will receive by mail the **PCHC Denial Letter for Managed Care Program**.

The Most Common Reasons for Denials

- Proof of address/residency was not provided
- All patients must present their primary insurance card(s) when going to an appointment of any kind when referred through the PCHC/CHS Services. This also includes emergency room visits. Managed Care will deny payments on any bill received if the primary insurance card(s) were not presented at the time of visit.
- The patient did not call PCHC CHS within 72 hours following an emergency room service or hospital stay.
- The patient resides **outside** the PCHC service delivery area (CHSDA), and thus is ineligible for PCHC CHS. *(6-Month -/- 180-day Rule, or 30 day rule)*
- Patient request for outside referral did not meet the requirements of the Managed Care Team at their review.
- The patient did not sign and date referral and take a copy of the referral to the appointment.
- The patient did not apply for potential resources or establish alternate resources or did not use the resources he/she had available.

APPROVED VISITS: If the Managed Care Team has authorized a requested referral, the patient will be given a phone call which will explain to the patient the following:

- The appointment time/date
- Reason for the referral
- Outside Provider's location
- If your records has been faxed and/or mailed to their office.
- It's the patients responsibility to pre-authorize with insurance, if needed. And present insurance information to the outside facility.

Step 8 – Cont. Denials and Appeal Process

What Should I Do if I Disagree with a CHS/Managed Care Denial Letter?

1. You should write a letter of appeal asking for your case to be reconsidered for payment.
2. This letter of appeal must be sent within *30 days* of receiving your denial letter.
3. The letter should state the reason you think the denial was a mistake and should include any additional information that has not been previously submitted. Please contact our office or stop by the CHS department if you need any help with this process.
4. Your letter should be addressed to the Peter Christensen Health Center, c/o Tribal Health Administrator, 129 Old Abe Road, Lac du Flambeau, Wisconsin 54538.
5. Your appeal will only be considered for the DOS specified on your denial letter. Prior fiscal years cannot be considered for payment.

Important Things Patients Really Need to Remember to Prevent Denials

1. Not everyone is eligible for PCHC CHS
2. Eligibility is determined by federal/tribal government regulations (eligibility criteria).
3. PCHC CHS has the authority to determine if you are eligible for CHS.
4. PCHC Doctor may refer you, but it does not mean CHS funds will be paying your bills.
5. Going to the hospital ER on your own, such as HYMC, when PCHC is open may result in a denial since PCHC was available. Make sure your attempt to be seen at PCHC prior to going to Urgent Care or ER. Speak to the triage nurse at PCHC.
6. When a patient receives checks for payments or partial payments of medical bills from his/her insurance company and CASH the checks without applying the entire amount to the bill, PCHC CHS **will not be responsible** for any portion of that medical bill. It will be the patient's responsibility to pay for that bill.
7. **Keep your Insurance.** If you have health insurance, we can pay for your deductible and any balances after the insurance company pays, assuming you meet all requirements of our CHS Program. For those who have insurance, all correspondence from insurance stating what they have paid or denied must be sent to us within **60 days** (Private Insurance, Medicare, etc.). If you fail to comply with the requirements of your primary insurance, CHS may deny payment. We pay only after all alternate resources have responded.

Denials due to Lack of Medical Necessity - Examples not covered:

- Durable medical equipment to be used at home without a PCHC provider script (such as wheelchairs, bedside commodes, shower chairs, hospital beds, dressings, etc.)
- Home healthcare and hospice
- Dermatology for skin conditions that do not threaten life or limb (such as acne or hair implants)
- Massage therapy, naturopathic therapy, biofeedback, acupuncture
- Cataract surgery unless it is medically approved

PCHC must **follow the regulations** to continue receiving CHS funds or to justify asking for more funds in the future.

Step 9
Contract Service Delivery Area

Care while you are here

Two types of services are provided by Peter Christensen Health Center: (1) Direct healthcare services which are provided at any IHS or Tribal Facility, or (2) Contract health services (CHS) which are provided by a non-IHS facility or provider through contracts with the PCHC.

CHS is provided principally for members of federally recognized tribes who reside on or near the reservation established by Congress through Code of Federal Regulation (CFR) at Title 42, Part 136 Subparts A - C.

The IHS designates and publishes a notice in the Federal Register, that specific geographic areas within the United States including Indian reservations and areas surrounding those reservations as CHSDA's (Contract Health Service Delivery Area) .

The Description of the PCHC Contract Health Service Delivery Area

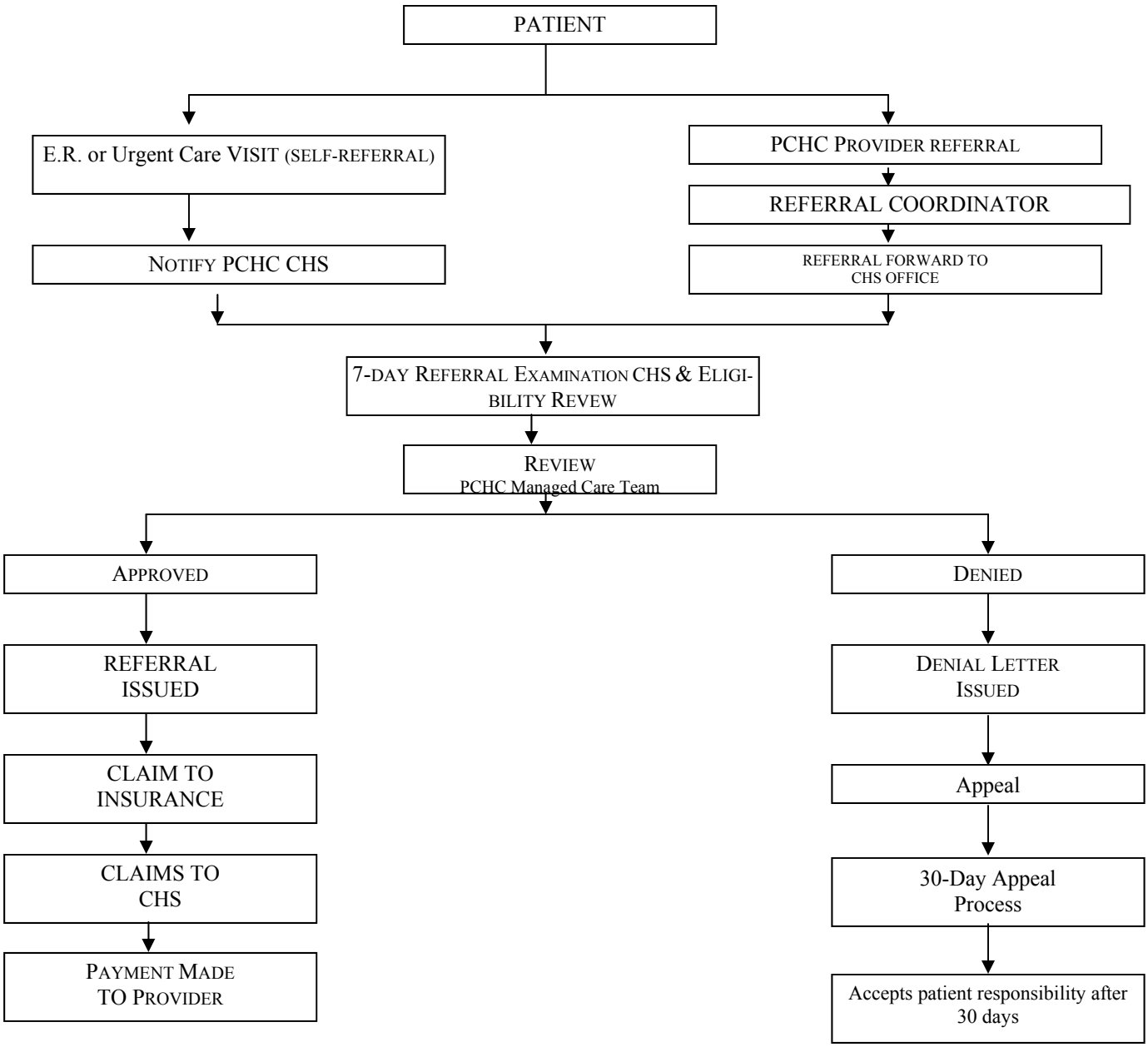
For the purpose of the Federal Register, notice to revise and update the list of the CHSDA's was last published in 2007. The current eligibility regulation at 42 CFR §136.22 (a)(1)-(5) defines certain CHSDA's by designating some areas as CHSDA's and certain counties within a state as a CHSDA. In addition, Section §136.22 (a)(6) provides that:

The counties included or excluded from the following list of CHSDA's were determined by applying the regulations at 42 CFR §136.22. The CHSDA list has been modified and updated to include the name of the tribe, with the respective reservation and counties comprising the CHSDA.

For PCHC - this includes: Vilas, Oneida, and parts of Iron counties (from LDF to Hurley, WI).

Step 10
CHS Authorization Process Flow

THE DIAGRAM ILLUSTRATES THE KEY PROCESSES involved when a patient receives authorization for CHS or whose care is deferred or denied.



Step 11
Managed Care Glossary and Terms

Alternate Resources – Such resources include healthcare providers, institutions and healthcare programs for payment of health services including but not limited to programs under Titles XVIII and XIX of the Social Security Act, Medicare, Medicaid, state, local healthcare programs and private insurance.

Appeal – A written request for review of a denial for payment of your medical services.

Billing Statement – The total amount of the cost of services billed to a customer, usually covering medical services made or services rendered within a specified period of time.

Catastrophic Health Emergency Fund (CHEF) – The fund to cover the IHS/CHEF portion of medical expenses for catastrophic illnesses and events falling within IHS/CHEF guidelines.

Co-Insurance – A provision in insurance policies that requires the enrollee to pay a percentage of all eligible medical expenses in excess of the deductible.

Consultation – Deliberation between physicians on a case or its treatment.

Contract Health Service Delivery Area (CHSDA) – Geographic area within which contract health services will be made available to members of an identified Indian community residing in the area (Reference Federal Register, Vol. 72, No. 119 June 21, 2007)

Contract Health Services Eligible Person – A person of Indian descent belonging to the Indian community/tribe with a Certificate of Indian Blood, proof as a member or a descendent of a Native American tribe residing within the United States on a reservation located within a (CHSDA) and either is a member of the tribe or tribes located on that reservation; or maintains close economic and social ties with that tribe or tribes.

Co-Payment – A provision in insurance policies that requires the enrollee to pay a flat fee for certain medical services.

Deductible – The portion of eligible medical expenses that the enrollee must pay before the plan will make any benefit payments.

Denied - for payment unable to justify payment for requested services due to IHS guidelines.

Eligibility – The established guidelines as identified in the Federal Regulations that a person must meet in order to receive the healthcare services

Emergency Care – A medical emergency includes an injury, sudden illness or suddenly worsening illness that would cause a reasonably prudent layperson to expect that delay in treatment may cause serious danger to the person's health if he/she does not get immediate medical care.

Explanation of Benefits (EOB}- Written statement to a beneficiary, from a third-party payer after a claim has been reported, indicating the benefits and charges covered or not covered by the benefits plan

Follow-Up – Maintenance of contact with or examination of a person (as a patient) especially <u>following</u> treatment. Most follow ups are done with PCHC provider.

Managed Care Team - Made up by the Administrative Team, CHS department, Benefits specialist and all providers.

Step 11 - Cont.
Managed Care Glossary and Terms

Non-Compliant – Refusing or failing to obey
Pre-OP- Occurring before a surgical operation

Pre-authorization/Pre-certification – A provision in insurance policies that requires prior approval by a healthcare plan or by a limited service health organization for services to be covered by a plan

Primary Care Provider- A physician, such as a general practioner, chosen by an individual to serve as his/her healthcare professional and capable of handling a variety of health-related problems, keeps a medical history and medical records on the individual and refers the person to specialists as needed

Primary Insurance – Coverage under an insurance policy

Referral – A process by which the primary care physician makes a request to receive medical care from an outside provider or specialist for care not available at the IHS facility

Secondary Insurance- Term utilized when referring to the presence of **insurance coverage** through two different sources at the same time. For example, a husband and wife may each have **insurance coverage** through their respective employers.

Surgery - A surgical operation or procedure

Urgent Care – Medically necessary care for an accident or illness that is needed sooner than a routine doctor's visit

72-Hour Notification – The patient or patient's representative must notify PCHC within 72 hours of the start of emergency services. If you are 55 years of age and/or disabled, you have 30 days to notify Contract Health Service of your emergency care **(§406 of P.L 94-437, as amended).**