DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W Holden Pl, Denver, CO 80204 PH: (303) 953-6600 FAX: (303) 781-4333

REQUEST FOR TRIBAL ENROLLMENT ID OR CERTIFICATE OF INDIAN BLOOD

Provide as much information as you are able. Please print clearly.

First Name: _____ Last Name: _____ Middle Initial: ___

Date of Birth: _____ Social Security Number: ___

Maiden/Legal Name: _____

Mother's (Maiden) Name: _____ *Father's Name:* _____

Name of TRIBAL AGENCY ENROLLED with: _____

Address: _____

City: _____ State: _____ Phone: _____ Fax: _____

Attention Tribal Agency,

Denver Indian Health and Family Services, Inc., is requesting Tribal Enrollment ID or Certificate of Indian Blood on behalf of the patient to be seen in our clinic.

REASON FOR REQUEST: Required to Establish Care or Continuity of Care as a Patient

REQUESTED BY: _____

DIHFS STAFF: _____ Title: _____ Date: _____

Please Mail or Fax Information to:

Denver Indian Health and Family Services, Inc.
2880 W HOLDEN PLACE
Denver, CO 80204

Or

Fax: 303-781-4333

I grant Denver Indian Health and Family Services, Inc. (DIHFS) permission to obtain Tribal Enrollment ID or Certificate of Indian Blood to be seen as a patient with the clinic for services.

I agree that if I am unable to obtain required documents to remain in compliance with DIHFS that I will be responsible for payment of charges as a self-pay patient, using the sliding fee scale unless I have Medicaid or Medicare. Payment is due when treatment is rendered.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature (if patient is a minor): _____ Date: _____