DENVER INDIAN HEALTH AND FAMILY SERVICES, INC.

2880 W HOLDEN PLACE, DENVER, CO 80204 PH: (303) 953-6600 FAX: (303) 781-4333 WWW.I

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: _____

Mothers (Maiden) Name: _____ *Fathers 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. permission to obtain Tribal Enrollment ID or Certificate of Indian Blood to be seen as patient with the clinic for services.

I agree 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: _____

PLEASE PRINT INFORMATION CLEARLY ● ALL INFORMATION IS CONFIDENTIAL (Rev.12/18)

Parent/Guardian signature (if minor): _____ Date: _____

Parent/Guardian (please print name): _____ Date: _____