



Prescription Assistance Program

Date: _____ CDIB No. _____

Name: _____ If child, Parents Name: _____

Address: _____
(Street Address) (City) (State) (Zip Code)

Date of Birth _____ Contact No. _____

Email _____

Name of Pharmacy _____ Diabetic: Yes ☐ No ☐

Assistance Requested: (Check all that apply): Prescription ☐ Medical ☐ Dental ☐

Insurance (Circle one): Medicare Medicaid Soonercare Other _____

The Prescription Assistance Program will provide assistance with medication, dental, or medical equipment that the Indian Health Service does not provide and assist with co-pays for those that have medical insurance. No voucher will be issued for cosmetic or male/female enhancement prescriptions.

To be eligible of services, the client must complete an application, provide a copy of CDIB, and submit a written prescription from a physician. It is the responsibility of the client to get all the necessary documents that is needed.

Upon receipt of a prescription for medication, a voucher will be issued for up to and not to exceed \$125.00. The difference over this amount will be the responsibility of the client. The Prescription Assistance program can assist clients once a month (30 days from last voucher issued). This program is not intended to replace any existing resources that the client may have access to such as, Medicare, Medicaid, Soonercare, private insurance, DHS, VA, or any other resources.

I have read and understand the policy and will abide by such:

Client Signature

Staff Signature

Comanche Nation P.O. Box 908 Lawton, OK 73502

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