RAMAH NAVAJO SCHOOL BOARD, INC.

TRADITIONAL HEALING CLAIM FORM

EMPLOYEE'S STATEMENT					
NAME OF EMPLOYEE:			SOCIAL SECURITY #:	BIRTHDATE:	
HOME ADDRESS:			PATIENT'S NAME:	PATIENT'S BIRTHDAY:	
CITY:	STATE:	ZIP:	IS PATIENT A FULL-TIME STUDENT: ☐ YES ☐ NO		
PATIENT'S RELATIONSHIP TO EMPLOYEE: ☐ SELF ☐ SPOUSE ☐ CHILD			PATIENT (PARENT OR EMPLOYEE) SIGNATURE: X		

EMPLOYER'S OR ADMINISTRATOR'S STATEMENT			
PLAN NUMBER: 13609	EMPLOYER: RAMAH NAVAJO SCHOOL BOARD, INC.	EFFECTIVE DATE:	TYPE OF COVERAGE: ☐ SINGLE ☐ FAMILY
VERIFIED BY:	TITLE: Insurance Administrator	DATE:	

PRACTITIONER OR TRADITIONAL HEALING INFORMATION	
DATES OF CEREMONY: FROM: __ / __ /__ THROUGH: __ / __ /__	DATES OF CONFINEMENT: FROM: __ /__ / __ THROUGH: __ / __ / __
TYPE OF TRADTIONAL HEALING:	FEE FOR DIAGNOSIS: $
	DIAGNOSIS: (CEREMONY)
PRACTITIONER NAME:	PRACTITIONER'S FEE: $
PRACTITIONER'S ADDRESS:	AMOUNT ALLOWABLE: $

RNSB INSURANCE ADMIN./TRADITIONAL HEALING COMMITEE	
DATE CLAIM RECEIVED:	
REVIEWED BY: INSURANCE ADMINISTRATOR	DATE:
DATE CLAIM SENT TO FOR REIMBURSEMENT:	

Revised 01/2014