Northern Cheyenne Tribal Health
TPSP
Tribal Premium Sponsorship Program

Tribal Premium Sponsorship Program

Medicare Part B Initial Contact Sheet

Name (***Please Print***): ________________________________ Date: ______________

Which district do you reside in? (***Check One***):

☐ **LAME DEER** ☐ **ASHLAND**

☐ **BUSBY** ☐ **BIRNEY** ☐ **MUDDY**

NC TPSP Program PRCDA
Rosebud
Big Horn
Carter

Do you reside within the **PRCDA** area? ☐Yes ☐No (*Please check one*)
(Purchased Referred Care Delivery Area indicated in BLUE OUTLINE area)

If so, where do you reside: ____

Are you an enrolled tribal member, OR a member of a federally recognized tribe?

☐Yes ☐No (*Please check one*)

What is your **Date of Birth**? ________/________/____________

What is your **Cell Phone Number**? ________________________________

Can TPSP Contact you **via TEXT**? ☐Yes ☐No (*Please check one*)

Do you have an **Email Address**? ☐Yes ☐No (*Please check one*)

Email Address: ____

Can TPSP Contact you **via Email**? ☐Yes ☐No (*Please check one*)

Do you currently have **Medicare Coverage**? ☐Yes ☐No (*Please check one*)

Do you receive a monthly **Part B Premium Deduction**? ☐Yes ☐No (*Please check one*)

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Office Use Only

Intake TPSP Staff (***Please Print***): ________________________________

Online Form Created 11/6/2025

Tribal Premium Sponsorship Program
Medicare Part B Application

Tribal Premium Sponsorship Program TPSP
100 Eaglefeathers Street
PO Box 67
Lame Deer, MT 59043
406.477.6722
tpsp.rep@nctribalhealth.com

Dear Potential Medicare Part B Applicant,

Please ensure that your application is complete and **REMEMBER** it is your responsibility to provide the following required documents:

1. **Social Security Award Letter**
   (Attach a copy of your **most recent** Social Security Award Letter.)

2. **Current Medicare Card**
   (Attach a copy of your current Medicare card **with valid proof of Medicare Part B**.)

3. **Tribal Enrollment/CDIB Document**
   (Include your Certificate of Degree of Indian Blood (CDIB) AND/OR your **Tribal ID Card**.)

4. **Proof of Residency**
   (Attach a document **signifying your physical address**, such as a utility bill, lease agreement, or bank statement.)

Once you gather these documents, please include them with your completed application and return them to us at your earliest convenience to avoid any delays in processing your application.

NOTE: *Please remember that the TPSP Medicare Part B Program is an incentive to you as a client and is subject to the availability of funds.*

Néá'eše (Thank you).

Terms and Conditions:

1. **I will** provide any requested information made by the NC TPSP Program; I further acknowledge that if I remain non-compliant with TPSP requested information, I risk being terminated from the Medicare Part B Reimbursement Program.

2. **I will** provide TPSP with any correspondence I may receive from Medicare, Medicaid, or any other State or Federal Agency regarding financial assistance that may affect the payment of my monthly Medicare Medical/Prescription Plan Premiums.

3. **I will** allow TPSP to educate and/or assist me in signing up for financial assistance in any Medicare/Prescription Drug Plans.

4. **I will** provide a copy of my new Medicare Card to NC TPSP annually.

5. **I will** provide TPSP notification and documentation of any changes in my premium amount. I understand that TPSP will only reimburse the current annual deductible for Medicare Part B, this will not include penalties.

6. **I will** notify TPSP if I move out of the IHS Service Delivery Area for the Northern Cheyenne Service Unit.

7. **I will** notify TPSP if my contact information changes including my address & phone number.

8. **I understand** that I will need to renew or reapply each fiscal year to remain eligible for the NC TPSP Medicare Part B Program.

9. **I understand** that I can be employed and am able to participate in the NC TPSP Medicare Part B Reimbursement Program.

10. **I understand** the Medicare Part B Reimbursement Program is a voluntary program limited to budget availability each fiscal year. If budgetary funds are unavailable, upon TPSP notification, I further understand that I will be liable to pay my own premium upon termination.

I hereby agree *with the above terms and conditions. I also authorize TPSP to use my personal identifying information for TPSP Office procedures.*

Applicant Name (***Please Print***): ____

Applicant Signature: ____

Date: ______________________________

Tribal Premium Sponsorship Program

Current Occupation & Social Media Form

Northern Cheyenne Tribal Health

Tribal Premium Sponsorship Program

Full Name *(Please Print)*: ______________________________

Current Occupation *(Please Print)*: ______________________________

Employer *(Please Print)*: ______________________________

Consent for Social Media Contact:

Do you give permission for the Northern Cheyenne Tribal Premium Sponsorship Program to contact you via your selected social media platforms?

☐ Yes ☐ No

Can we communicate with you via social media? (Select all that apply):

☐ Facebook including Messenger
☐ Instagram
☐ Snapchat
☐ X (formerly Twitter)

Social Media Handles (for contact purposes):

Facebook Handle: ______________________________

Instagram Handle: ______________________________

Snapchat Handle: ______________________________

X (Twitter) Handle: ______________________________

Signature: ______________________________

Date: ______________________________

Online Form Updated 11/6/2025

MR #: ______________________________ *(Office Use Only)*

Applicant Information:

Full Name (*Please Print*)**:** ______________________________

Date of Birth: ________/________/________

Social Security Number: ________-________-________

Mailing Address: ______________________________

Physical Address: ______________________________

Home Phone: ______________________________

Cell Phone: ______________________________

Email Address: ______________________________

Tribal Enrollment Number: ______________________________

Medicare Number: ______________________________

1. Do you have Part B Health Insurance? ☐**Yes** ☐**No** (*Please check one*)
2. Do you reside on or near the Northern Cheyenne Reservation?

   ☐**Yes** ☐**No** (*Please check one*)

   If Yes, Location of Residence: ______________________________
3. Are you IHS Eligible? ☐**Yes** ☐**No** (*Please check one*)
4. Are you currently employed? ☐**Yes** ☐**No** (*Please check one*)

   If yes, do you receive a CMS 500 Form? ☐**Yes** ☐**No** (*Please check one*)
5. Is your Medicare Part B Premium deducted from your monthly Social Security Benefits, Railroad Retirement Board, or Office of Personnel Management Benefits OPM?

   ☐**Yes** / ☐**No** (*Please check one*)

   If Yes, Please Specifically List: ______________________________

   Is your Medicare Part B Premium deducted:

   ☐**Monthly?** ☐**Quarterly?** (*Please check one*)

I, ____, (***Client Name Please Print***), hereby attest my signature, and agree to the terms and conditions for my application.

Applicant Signature: ____

Reviewed and accepted by:

____ _________________________________

TPSP Representative | Date

____ _________________________________

TPSP Program Manager | Date

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Office Use Only

Date Completed*:* ______________________

☐ **Not Approved**, reason why: ____

____

☐ **Approved**, determined by TPSP Team, Date: ______________________________________

☐ **Approval confirmed** by TPSP Program Manager (Initials): ____________

Online Form Updated 11/6/2025

Northern Cheyenne Tribal Health — Tribal Premium Sponsorship Program

Tribal Premium Sponsorship Program

Authorized Individual(s) for Check Pick-Up Form

I, ____ (***Please Print***), authorize my check to be **mailed** to me; **OR** I authorize the following individual(s) to **pick-up** my Medicare Part B Reimbursement in case I am unable to. I understand that if any individual is not listed by me, he/she will not be able to pick up my check. I further understand that I am only able to list up to three additional individual(s), if, for any reason, my check cannot be picked-up during the recognized disbursement week, I acknowledge that the NC TPSP Program will mail my Medicare Part B Reimbursement check by the close of business of the last day of the recognized disbursement week.

1. ____ (***Please Legibly Print***)
   Primary Authorized Individual

2. ____ (***Please Legibly Print***)
   Alternate Authorized Individual

3. ____ (***Please Legibly Print***)
   Alternate Authorized Individual

ATTENTION: ONLY check the box, if you want your check mailed to you.

☐ I **elect** to have my Medicare Part B Reimbursement check mailed to me.

____ ________________________________

Signature of Medicare Part B Reimbursement Client Date

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Office Use Only

Date Received: __________________________

Authorized Individuals Confirmed by TPSP Staff: ____