Please submit ORIGINAL completed claim to:
Navajo Nation Employee Benefit Program
PO Box 1360
Window Rock, AZ 86515

NATIVE TRADITIONAL HEALING BENEFIT REIMBURSEMENT FORM

EMPLOYEE'S STATEMENT (To be completed by Employee)--**BLACK INK only**

Employee's Name: _____Health Insurance Member ID No.: _____
(Do not indicate SS No.)

Names of Covered Member(s) Who Received Services: _____

_____

Mailing Address: _____

Employer: ❒ NAVAJO NATION ❒ ENTERPRISE OR CHAPTER_____
(Name must be indicated)

I certify that the healing ceremony indicated below was performed for me and/or my covered dependents by a commonly recognized or authorized Native Traditional Practitioner. I hereby request reimbursement in the amount of $_____ for the ceremony. I authorize the Native Traditional Practitioner to verify information contained only on this form. (Receipts not required)

Traditional Practitioner(s) $_____ Materials $_____ Food $_____ (**Please Itemize**)

NATIVE TRADITIONAL PRACTITIONER'S STATEMENT (To be completed by Native Practitioner)

Native Traditional Practitioner's Name (Please Print): _____

Census No. _____Tribal Enrollment Affiliation _____Telephone No.: _____
(Optional)

Mailing Address (No General Delivery or Trading Post): _____
Street Address or Post Office Box City State Zip

CEREMONY PERFORMED – Check appropriate box(s)

❒ DIAGNOSIS ❒ PROTECTION/PREVENTION ❒ BLESSING WAY ❒ OTHER _____
(Name of ceremony must be indicated)

Date(s) Ceremony was Performed _____
(Month/Day/Year REQUIRED)

(Separate claim form must be submitted for each date of service unless one ceremony lasts for more than one day, consecutively)

PATIENT(S) (must match above): ❒ EMPLOYEE ❒ EMPLOYEE'S SPOUSE ❒ EMPLOYEE'S CHILD(REN)

Native Traditional Practitioner's Recommendations or Comments (Optional):

_____

_____ _____
Signature (THUMB PRINT) of Native Traditional Practitioner Date
(REQUIRED to validate claim)

EMPLOYEE BENEFIT PROGRAM'S REVIEW (To be completed by EBP)

❒ Authorized for Payment