



Pokégnek Bodéwadmik * Pokagon Band of Potawatomi
Department of Social Services

Box 180 • 58620 Sink Road • Dowagiac, MI 49047 • www.PokagonBand-nsn.gov
(269) 782-8998 • (800) 517-0777 toll free • (269) 782-4295 fax

Medicare Part B Reimbursement Application

Name _____

Street Address _____

City _____

State _____

Zip _____

Date of Birth _____

Social Security Number _____

Enrollment Number _____

Phone Number _____

() I understand that I can only be reimbursed up to the standard \$144.60 Medicare Part B deduction.

Medicare Part B medical insurance premium deduction amount \$ _____

You must enclose a copy of your Medicare Card and Social Security benefit statement.

It is imperative that you notify the Department of Social Services, specifically regarding this program, of any changes in your Social Security plan that may affect your eligibility in this program. Failure to report such changes will result in your removal from program.

- I understand that giving false or incomplete information can result in referral to the prosecuting attorney for fraud and/or recovery of funds paid on my behalf.*
- I hereby authorize the release of information by the appropriate agencies to the Pokagon Band of Potawatomi Indians, for the purposes of verifying information needed to establish eligibility for the program.*

Signature _____

Date _____

Contact information: beth.warner@pokagonband-nsn.gov

Elders Program PO Box 180 Dowagiac MI 49047

(269) 782-0765 Toll Free (800) 859-2717 Fax: (269) 782-1696

For Official Use Only

() Medicare Application Approved _____

Sign and Date

A proud, compassionate people committed to strengthening our sovereign nation.

A progressive community focused on culture and the most innovative opportunities for all of our citizens.