U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
INDIAN HEALTH SERVICE

ORDER FOR HEALTH SERVICES

Instructions to complete the order and claim submission on reverse side of Original form.
Order Provisions and Clauses on reverse of Copy 3 - Provider

1. ORDER NO.

2. PATIENT IDENTIFICATION

3. HEALTH INSURANCE COVERAGE
a. Name of Policy Holder:
b. Plan Name:
c. Address:
d. Policy No.:
e. Coverage Type: ☐ Current ☐ Previous
f. Effective Date:
g. Termination Date:
h. Other Health Insurance Coverage:

4. IHS ORDERING FACILITY

5. HOSPITAL INPATIENT ☐ 6. DENTAL ☐ 7. OTHER THAN HOSPITAL INPATIENT OR DENTAL ☐

8. ESTIMATED CHARGES $

9. FISCAL YEAR CAN

10. OBJECT CLASS CODE

REFERRAL AND AUTHORIZING INFORMATION

11. AUTHORIZATION VALID (From)
(To)

12. SERVICES ORDERED

PROOF

13. REASON FOR REFERRAL

14. REFERRING IHS PHYSICIAN

15. REFERRING IHS DENTIST

16. MEDICAL / DENTAL PRIORITY

PRICING INFORMATION

17. IHS NO. OF a. ☐ Contract, b. ☐ Agreement, or c. ☐ Rate Quotation:

18. DATE OF RATE QUOTATION *(if applicable):*

19. RATE FOR AUTHORIZED SERVICES: a. ☐ Medicare Rate, or b. ☐ Other Rate *(Specify)*:

20. TITLE

21. SIGNATURE *(IHS ordering official)*

22. DATE SIGNED

23. PAYMENT IS HEREBY AUTHORIZED BY *(IHS authorizing official)*

24. DATE SIGNED

25. AMOUNT APPROVED $

PROVIDER INSTRUCTIONS, IDENTIFICATION, AND CERTIFICATION

26. PROVIDER
a. Name
b. Address
c. Telephone Number ( )
d. EIN No.
e. UPIN No.

27. PROVIDER CLASSIFICATION *(Check appropriate boxes)*
a. ☐ Small Business b. ☐ Small Disadvantaged Business c. ☐ Woman-Owned Small d. ☐ HUBZone Small Business e. ☐ Other

28. INSTRUCTIONS
If IHS has not completed Block 19 above, the provider should indicate its rate for the authorized services in that Block. It is IHS policy to pay Medicare rates or equivalent or lower rates for health care services.

IHS has approved payment to you for services necessary to treat the patient's immediate condition. Any additional services must be approved by the IHS authorizing official and may require an additional purchase-delivery order.

The provider shall submit CMS 1450-1500 or ADA Dental Form for payment to: _____

_____ . Additional instructions for submitting claims are included on the reverse side of this form, and the conditions and clauses pertaining to the order are included on the reverse side of Copy #3 of the purchase-delivery order.

29. SIGNATURE OF PROVIDER DATE

I certify that I have provided the authorized services:

INSTRUCTIONS ON COMPLETING THE PURCHASE-DELIVERY ORDER AND SUBMITTING A CLAIM FOR PAYMENT

Provider Responsibilities:

Item 19. IHS and the Health Care Provider normally reach agreement on a reimbursement rate through a contract, agreement, rate quotation, or other means before orders are issued to the Provider. When this has occurred, the IHS ordering facility will cite the agreed upon rate on Line 19 on the face of this form. If IHS does not cite an agreed upon rate, the Provider should use Line 19 to indicate a rate for furnishing the authorized services (e.g., Medicare rate, a specific percentage of billed charges, etc.).

Item 29. The Provider must certify that it has delivered the authorized services by signing Line 29 of the purchase-delivery order form. If the Provider fails to sign Line 29, the form may be returned to it for signature prior to payment of the claim.

Claim The Provider should submit its claim for payment to the claims processing office identified in Item 28. Claims must be submitted on a HCFA 1450 or 1500 form or ADA dental form unless IHS has specifically agreed to accept another claim form for the type of service involved. The claim must be accompanied by the signed, original copy of the purchase-delivery order form. If the patient is eligible for an alternative resource, the claim must also be accompanied by an Explanation of Benefits report which indicates that the alternative resource has paid its proper share of the claim. The Provider is encouraged to submit its claim within 10 days following the completion of the service, and shall submit its claim within one year of that date to receive payment.

IHS Entries

Data items 1 through 28 are normally completed by the IHS facility placing the order. Explanations for items which may not be self-explanatory are furnished below.

Item 2. Name, address, and other information on the patient being referred for care.

Item 3. The alternative resource(s) that must be billed prior to IHS. See section entitled "Payor of Last Resort" under Conditions and Clauses on the reverse side of Copy #3 of this form.

The following codes are used under 3e. to describe the nature of the alternate resource coverage:

A - Medicare Part A
B - Medicare Part B
C - Medicaid
D - Dental Coverage
MS - Medical/Surgical Coverage
V - Vision Coverage

Multiple codes are used as appropriate; e.g., A and B for an individual with both Medicare Part A and Part B coverage.

Item 8. The amount of funds obligated by the IHS facility when it issued the order for the services. This amount may not precisely correspond to the subsequent, actual payment.

Items 9. and 10. Fiscal information for internal IHS use.

Item 11. The date(s) on which the Provider is authorized to perform the services identified in Item 12.

Item 12. The service which the Provider is authorized to furnish.

Item 13. The diagnosis or reason why the patient is being referred to the provider.

Items 14. and 15. The name of the IHS physician or dentist, in the IHS ordering facility, who referred the patient for the authorized services.

Item 16. For internal IHS use.

Item 17. Identification number of the contract, agreement, or rate quotation, if any, which the provider has established with IHS.

Item 18. Date when the Provider furnished the rate quotation (If applicable).

Item 19. The agreed upon rate for the authorized services. This rate is normally established in a contract, agreement, or rate quotation covering all orders issued during a specified period of time, but may also be agreed upon on an order-by-order basis.

Items 20. and 21. Title and signature of the IHS official authorizing the services identified in Item 12.

Item 23. For internal IHS use following delivery of the authorized services.

Item 26. The Health Care Provider that is authorized to furnish the services identified in Item 12.

Item 27. The size and socioeconomic classification of the Provider based on definitions contained in Part 19 of the Federal Acquisition Regulation.

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ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

Public reporting burden for this collection of information is estimated to average 3 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. For hospital inpatient services, the Inpatient Discharge Summary will require an additional burden of 3 minutes. The Indian Health Service (IHS) may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: IHS Reports Clearance Officer, 801 Thompson Avenue, TMP Suite 450, Rockville, MD 20852, ATTN-PRA 0917-0002. Do not return the completed form to this address.

PRIVACY ACT NOTIFICATION (IHS Supplement)

This procurement action authorizes the Contractor, on behalf of the IHS, to provide health care to American Indians and Alaskan Natives and report selected medical record and financial information to IHS. The Snyder Act (25 U.S.C. 13) and Public Law 83-568 (42 U.S.C. 2001) authorize the collection of information. To be reimbursed by IHS, you must provide the information requested by this form. IHS will use the information for financial, legal, research, and health care purposes.

Disclosure of this information may be made by IHS to: other providers of health care for treatment or health maintenance of American Indian or Alaskan Native people; the Office of Worker's Compensation Programs, Department of Labor; the Department of Justice for their representation of the United States; and for Congressional inquiry; quality assessment, medical audit, or utilization review; billing third parties for the payment of care; analytical and evaluation studies; to Federal or State agencies as required by law; research purposes supported by IHS; and the identification of handicapped children under 10 U.S.C. 1401 et. seq.

Disclosure of the appropriate medical record information without prior consent of the subject patient may be made by you to: another provider of health care treating the same patient; a Federal or State agency as required by law such as the reporting of communicable diseases, births, deaths, or the commission of crimes (i.e., gunshot wounds, rape, child abuse or neglect, alcohol or drug abuse, etc.) and billing parties for the payment of care not reimbursed by IHS. You must forward all other requests for information contained on this form to the applicable IHS Ordering Official.

CONTRACT DISPUTES ACT

Procedures to be followed Prior to Filing a Claim under the Contract Disputes Act:

The provider agrees that, prior to filing any claim under the procedures set forth in the Contract Disputes Act (CDA), 41 U.S.C. 601, et. seq., it shall, on behalf of the patient, file an appeal in accordance with the Contract Health Services (CHS) appeals process provided for in CHS regulations at 42 C.F.R. 36.25 (1986).

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(BACK OF COPY 2 - CHSO)

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ORDER PROVISIONS AND CLAUSES

The following provisions and clauses apply when Item 17 on the front of this form indicates that the order is being issued against a rate quotation. They also apply when Item 17 indicates that the order is being issued without benefit of an applicable contract, agreement, or rate quotation (i.e., when Item 17 is blank). When Item 17 indicates that the order is being issued under a contract or agreement, the provisions and clauses contained in the contract or agreement apply rather than those included below.

I. RECORDS AND QUALITY OF CARE

The Provider shall furnish IHS patients proper, adequate and cost effective services which are the same or equal to those provided to non-IHS, patents, without discrimination based on race, color, creed, or national origin. Each patient shall receive treatment with sensitivity to his/her cultural and religious needs.

The Provider shall comply with applicable standards of the Joint Committee on Accreditation of Healthcare Organizations, include hospitalized IHS patients in its facilities utilization review program, perform discharge planning responsibilities for these patients, and provide physician and ancillary services within acceptable professional standards.

The designated IHS official or his/her representative is authorized to examine IHS patients and appraise their general status. An IHS official or authorized representative is also entitled to review the quality of care rendered under the purchase-delivery order by on-site survey, record review, or other reasonable methods. The Provider shall maintain clinical, business, and supply records and quality assurance committee reports which are adequate to assess both the quality of care rendered and the accuracy of the claim submitted. Payment will not be made if the IHS, PSRO, or other review organization designated by IHS determines that the care or a portion thereof was not medically necessary, not within current IHS medical priorities, or did not receive required prior authorization by IHS.

When the IHS is carrying out its duties with respect to the conservation of the health of Indians, the relationship of the IHS to the Indian shall be regarded as that of physician to patient; i.e., the restrictions generally applicable to the release of clinical information by the Provider will not be applicable to the release of such information to IHS.

II. DISCHARGE SUMMARY AND REPORTING REQUIREMENTS

The Provider must furnish IHS with a narrative of the care furnished at the time that an inpatient is transferred to an IHS facility, and within 30 days of discharge or prior to subsequent care by IHS for other inpatients. The Provider shall also be responsible for advising the IHS ordering official of any of the following by telephone, within 24 hours of their occurrence: (1) a communicable or infectious disease which requires public health intervention, (2) the discharge of a newborn and/or mother within 24 hours of admission, or (3) the death of an IHS patient. Reporting on the latter shall include the patient's name, parentage for infants and children, cause/date/time of death, and name of attending physician.

III. PAYOR OF LAST RESORT

In accordance with regulations identified under 42 CFR 36.61 IHS is the payor of last resort for individuals eligible for its contract health services. As a result, the Provider is not authorized to receive payment under this order to the extent that the Indian patient is (1) eligible for an alternate resource (e.g., Medicare, Medicaid, or private health insurance), (2) would be eligible for an alternate resource if he/she applied for it; or (3) would be eligible for an alternate resource under State or local law or regulation if he/she were not an IHS beneficiary.

When the patient is potentially eligible for an alternate resource, the Provider is responsible for assisting him/her in completing application forms necessary to receive the benefit.

IV. RESTRICTION ON BILLING IHS PATIENTS

The Provider shall accept the amount allowed under the order as payment in full for the authorized services (i.e., shall not bill the patient for any additional amount) unless IHS determines that the patient is ineligible for IHS contract health care benefits or has failed to apply for or utilize an alternate resource (see above). In the latter situations, the patient is responsible for paying for the services.

V. MEDICAL MALPRACTICE

This is a nonpersonal services contract, as defined in Federal Acquisition Regulation Subpart 37.101, involving the provision of professional services by an independent contractor.

The Provider shall maintain medical malpractice insurance in the form and minimum amount required by the State in which the services are performed, and shall promptly notify IHS in the event of a malpractice suit or action involving an IHS patient. The Provider shall authorize IHS representatives to collaborate with counsel for the insurance carrier in settling or defending such claims when the amount of the liability claimed exceeds the amount of the coverage.

VI. STERILIZATION, THERAPEUTIC ABORTIONS, AND IRREVERSIBLE PROCEDURES

The Provider must comply with extensive Federal regulations in performing sterilizations, therapeutic abortions, and irreversible procedures. Information on these regulations is available from IHS.

VII. FEDERAL ACQUISITION REGULATION (48 CFR CHAPTER 1)

FAR 52.252-2, Clauses Incorporated by Reference (Feb 1998). This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address: http://www.arnet.gov/far/index.html

Clause No.	Title and Date
52.213-4 Than	Terms and Conditions-Simplified Acquisitions (Other Commercial Items) (Feb 2006)
52.204-7	Central Contractor Registration (Oct 2003)

VIII. HEALTH AND HUMAN SERVICES ACQUISITION REGULATION REQUIREMENTS (HHSAR)

This contract incorporates one or more clauses by reference, with the same force and effect as if they were given in full text. Upon request, the Contracting Officer will make their full text available. Also, the full text of a clause may be accessed electronically at this address: http://www.hhs.gov/oamp/dap/hhsar.html

Clause No.	Title and Date
352.224-70	Confidentiality of Information (April 1984)
352.270-2	Indian Preference (Apr 1984)
352.270-7	Paperwork Reduction Act (Jan 2001)

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