UPDATED 2/2019 v2

MONTHLY SERVICE REQUEST FORM
Insurance Services Program (ISP)

Date of Service Request: ________________

My client __________________________ having social security number ______________________________ is enrolled OR waitlisted for the Insurance Services Program.

Signature below indicates that I have confirmed the following:

☐ my client has a current Notice of Eligibility

☐ my client has annual income of: ☐ 0-199% FPL ☐ 200%-250% FPL ☐ 251-300% FPL ☐ 301-400% FPL

My client has the following type of insurance policy:

☐ ACA Policy ☐ Employer-Sponsored Policy ☐ COBRA Policy ☐ Medicare/Medicaid Policy

The last documented date on which I had contact with my client was: ____________

SERVICES REQUESTED THIS MONTH

HEALTH INSURANCE*
*Attach premium notice

☐ Premium (max of $400/client/month)

Premiums

Premium Requested: $ ________________________

Insurance Company: ________________________

Make Payable To: ________________________
____

Mail Payment To: ________________________
____

Coverage Period: ________________________

Policy Number: ________________________

SHARE OF COST SCHEDULE - NOT YET IMPLEMENTED

% FPL	% SHARE OF COST
0% - 199%	0%
200% - 250%	5%
251 - 300%	10%
301% and Over	Not Eligible

CO-PAYMENTS*
**Attach pharmacy list OR provider invoice
***Proof of relation to HIV disease must be attached for co-pays or deductibles for EMS and out-patient hospital care

☐ Co-Payment (max of $275/client/month)

Medications

RX Co-Payment Requested: ________________________

Pharmacy: ________________________

Address & Fax #: ________________________

% Share of Cost (SEE Schedule)

$ Client Share

TOTAL $ ALLOWABLE ________________________

Office Visits/Lab Fees

Office/Lab Fees Requested: ________________________

Provider: ________________________

Address & Fax #: ________________________

% Share of Cost (SEE Schedule)

$ Client Share

TOTAL $ ALLOWABLE ________________________

TAX ID NUMBER* ________________________

*Tax ID number must be provided when requesting payments to clinic, lab, private physician or hospital

Signature below attests that I have had documented contact with my client within the last 60 days; that I intend to continue to have contact with them at least every 60 days to keep them eligible for ISP services; and that these services were HIV-related.

CASE MANAGER'S NAME	AGENCY NAME	PHONE #	FAX #

PLEASE RETURN BY FAX TO BARBARA HAY AT 727-570-3033