UPDATED MARCH 2015

INSURANCE SERVICES PROGRAM
REQUEST FOR ENHANCED BENEFITS

Date of Enhanced Benefits Request: _____

(**Please Note Benefit Levels:** Access to enhanced benefits is limited to $300 per client; however, exceptions may be made based on special circumstances. No client is guaranteed access to enhanced benefits. Access to enhanced benefits is subject to the availability of funds.

My client _____ SS # _____ is either enrolled in the *Insurance Services Program* administered by Suncoast Health Council *or* he/she is wait-listed for program services.

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

PREMIUM, DEDUCTIBLE, OFFICE CO-PAY OR CO-INSURANCE		PRESCRIPTION DRUG CO-PAYMENTS	
AMOUNT REQUESTED	**$**	**AMOUNT REQESTED**	**$**
PROVIDER OR INSURANCE COMPANY NAME		**PHARMACY NAME**	
TAX ID NUMBER* *must be provided if payment is to be made to clinic, lab, private physician or hospital			
ADDRESS		**ADDRESS**	
COVERAGE PERIOD		**FAX NUMBER**	
POLICY NUMBER			

Signature below attests that I have had documented contact with my client within the last 60 days, and that I intend to continue to have contact with him/her at least every 60 days to keep him/her eligible for ISP services.

CASE MANAGER'S SIGNATURE **AGENCY** **PHONE #** **FAX #**

PLEASE RETURN BY MAIL OR FAX TO:

Suncoast Health Council, Inc. Attention: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033