UPDATED 6/2018

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 but exceptions may be made for special circumstances. No client is guaranteed access to enhanced benefits.

My client ______________________________ SS # ______________________ is either enrolled OR waitlisted in the *Insurance Services Program* administered by Suncoast Health Council, Inc.

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

My client has the following type of insurance policy:

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

ENHANCED BENEFITS REQUESTED

HEALTH INSURANCE*

*Attach premium invoice

☐ Premium

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

☐ Co-Payment

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, 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