UPDATED MARCH 2015

MONTHLY SERVICE REQUEST FORM
Insurance Services Program (ISP)

Date of Service Request: _____

My client _____ having social security number _____ is:

☐ Enrolled OR wait-listed for the Insurance Services Program

☐ I have submitted the following documentation to Suncoast Health Council, Inc.:

☐ Initiation of Services Form ☐ Insurance Card AND Brief Benefits/Pharmacy Summary (See Sample)

My client is (check one): ☐ on HIV drug therapy ☐ not on HIV drug therapy
My client has income less than or equal to 400%FPL: ☐ Yes ☐ No
The last documented date on which I had contact with my client was: _____

SERVICES REQUESTED THIS MONTH

HEALTH INSURANCE

☐ ISP (up to max of $400/client/month)

Premium Requested: $_____
Insurance Company: _____

Make Payable To: _____

Mail Payment To: _____

_____

Coverage Period: _____

Policy Number: _____

PRESCRIPTION DRUG CO-PAYMENTS*

☐ ISP (Any medications up to max of $275/client/month)

*Attach medication list for which co-pays are requested.

	ARV Meds	Non-ARV Meds
Drug Co-Payment Requested:	$_____	$_____

Pharmacy: _____
Address & Fax #: _____

_____

Other Support Requested:

Office Visit Co-Pay	Deductible Fee
$_____	$_____

Provider: _____
Address & Fax #: _____

_____

TAX ID NUMBER*
*must provide 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. My signature also attests that I have: 1. attached a copy of my client's Initiation of Services Form AND a Benefits & Pharmacy Services Summary; AND 2. confirmed that the policy/group number listed on my client's health insurance card 'matches' the policy/group number listed on my client's Summary of Insurance Benefits in cases where the Summary of Insurance Benefits doesn't include the client's name in the documentation.

_____	_____	_____	_____
CASE MANAGER'S NAME	**AGENCY NAME**	**PHONE #**	**FAX #**

PLEASE RETURN BY MAIL OR FAX TO

Suncoast Health Council, Inc. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)217-7734

SUNCOAST HEALTH COUNCIL

UPDATED MARCH 2015

2014 Benefits at a Glance

Humana Gold Plus® SNP-DE H1036-102 (HMO SNP) Tampa

Plan Costs	In-Network
Monthly plan premium	$8.60
Annual out-of-pocket maximum	$3,400
Doctor Office Visits	
Primary care physician (PCP)	$0 copay
Specialist	$0 copay
Preventive Care	
Annual wellness visit	$0 copay
Immunizations (including Flu vaccine)	$0 copay
Cholesterol screening	$0 copay
Colorectal cancer screening	$0 copay
Breast cancer screening	$0 copay
Inpatient Care	
Acute inpatient hospital care	$0 per admit
Skilled nursing facility care	$0 per admit
Emergency Services	
Ambulance services	$25 copay
Emergency room	$25 copay
Urgently needed care	$0 copay
Prescription Drugs	
Pharmacy deductible	$310
Depending on your income and institutional status, you pay the following: — Generic drugs (including brand drugs treated as generic) either:	— **$0** copay or — **$1.20** copay or — **$2.55** copay or — **15%** of the cost

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SUNCOAST
HEALTH COUNCIL

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BENEFIT	ORIGINAL MEDICARE	Humana Gold Plus SNP-DE H1036-102 (HMO SNP)
5) **Outpatient Prescription Drugs**	• Most drugs are not covered under Original Medicare. You can add prescription drug coverage to Original Medicare by joining a Medicare Prescription Drug Plan, or you can get all your Medicare coverage, including prescription drug coverage, by joining a Medicare Advantage Plan or a Medicare Cost Plan that offers prescription drug coverage.	**Drugs covered under Medicare Part B** **General** • **$0** yearly deductible for Medicare Part B drugs.* • **$0** copayment for Medicare Part B chemotherapy drugs and other Part B drugs.* **Drugs covered under Medicare Part D** **General** • This plan uses a formulary. The plan will send you the formulary. You can also see the formulary at **http://www.humana.com/medicare/medicare_prescription_drugs/medicare_drug_tools/medicare_drug_list/** on the web. • Different out-of-pocket costs may apply for people who – have limited incomes, – live in long term care facilities, or – have access to Indian/Tribal/Urban (Indian Health Service) providers. • The plan offers national in-network prescription coverage (i.e., this would include 50 states and the District of Columbia). This means that you will pay the same cost-sharing amount for your prescription drugs if you get them at an in-network pharmacy outside of the plan's service area (for instance when you travel). • Total yearly drug costs are the total drug costs paid by you, the plan, and Medicare. • The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition. • Some drugs have quantity limits. • Your provider must get prior authorization from Humana Gold Plus SNP-DE H1036-102 (HMO SNP) for certain drugs. • You must go to certain pharmacies for a very limited number of drugs, due to special handling, provider coordination, or patient education requirements that cannot be met by most pharmacies in your network. These drugs are listed on the plan's website, formulary, printed materials, as well as on the Medicare Prescription Drug Plan Finder on Medicare.gov.

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