UPDATED 6/2018

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

C0-PAYMENTS*
****Attach pharmacy list OR provider invoice**

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

Medications

RX Co-Payment Requested: _____

Pharmacy: _____

Address & Fax #: _____

% Share of Cost (SEE Schedule) [redacted]

$ Client Share

TOTAL $ ALLOWABLE _____

Office Visits/Lab Fees

Office/Lab Fees Requested: _____

Provider: _____

Address & Fax #: _____

% Share of Cost (SEE Schedule) [redacted]

$ 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 NAME	AGENCY NAME	PHONE #	FAX #
_____	_____	_____	_____

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