SUNCOAST HEALTH COUNCIL

UPDATED 9/2019

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: _____

CO-PAYMENTS*
****Attach pharmacy list OR provider invoice**
*****Article name from Documentation Library must be provided as proof of relationship to HIV disease for all out-patient claims.**
NO IN-PATIENT CLAIMS ACCEPTED

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

Medications

RX Co-Payment Requested: _____

Pharmacy: _____

Address & Fax #: _____

TOTAL $ ALLOWABLE _____

Office Visits/Lab Fees

Office/Lab Fees Requested: _____

Provider: _____

Address & Fax #: _____

TOTAL $ ALLOWABLE _____

Diagnosis/Disorder & Article: _____

Example Heart Disease

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