UPDATED MARCH 2015

INSURANCE SERVICES PROGRAM
NOTICE OF CHANGE FORM

Date: _____

☐ Please **CHANGE** the following information regarding my client _____

Social Security _____ who is either enrolled in or wait-listed for services through the *Insurance Services Program* administered by Suncoast Health Council, Inc.

☐ **Demographic Change** (Note on Client Demographics)

☐ **Insurance Policy Change** (Attach copy of client's new health insurance policy benefit summary, including a description of pharmacy benefits)

☐ Please **DISENROLL** my client from program services *(do not complete other information; just sign, date, and return form)*

My client (check one): ☐is on HIV drug therapy ☐is not on HIV drug therapy

CLIENT DEMOGRAPHICS

(please CHANGE the following information per the codes specified in County MAR memorandum)

Social Security Number	Gender	Ethnicity	Race	Income	Housing/Living Arrangements

Medical Insurance	HIV/AIDS Status	Enrollment Status	DOB	Exposure

COUNTY OF RESIDENCE *(check one):*

	Hardee		Highlands		Manatee		Pinellas
	Hernando		Hillsborough		Pasco		Polk

I attest that I have personally reviewed all appropriate documentation required to make the change in demographics specified above.

CASE MANAGER'S SIGNATURE **AGENCY** **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)570-3033