THE HEALTH COUNCILS INC.
We Make Health Care Better

COMBINED REQUEST FORM - 12/2011

MONTHLY SERVICE REQUEST FORM

AIDS Insurance Continuation Program (AICP) and Insurance Services Program (ISP)

Date of Service Request: _____

My client _____ residing in zip code _____ and having social security number _____ is ***(check both boxes if client is dually enrolled in AICP and ISP)***:

☐ Enrolled in the AIDS Insurance Continuation Program (AICP)

☐ Enrolled OR wait-listed for the Insurance Services Program RWIS # _____

☐ I have submitted the following documentation to The Health Councils, Inc.:

☐ RWIS consent form

☐ Copy of client's health insurance policy benefit summary, including a description of pharmacy benefits

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

☐ AICP (up to max of $750/client/month)

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

PRESCRIPTION DRUG CO-PAYMENTS*

☐ AICP (ADAP formulary up to max of $100/client/month)

☐ ISP (Any medications up to max of $175/client/month)

*Attach medication list for which co-pays are requested. Use X to indicate medications on ADAP formulary

Premium Requested: $_____

Insurance Company: _____

Make Payable To: _____

Mail Payment To: _____

_____

Coverage Period: _____

Policy Number: _____

	ADAP Meds	Non-ADAP Meds
Drug Co-Payment Requested:	$_____	$_____
Pharmacy:		
Address & Fax #:		

GRANDFATHERED AICP PATIENTS ONLY (Enrolled prior to 7/1/01)	Office Visit Co-Pay	Deductible Fee
	$_____	$_____
Provider:		
Address & Fax #:		

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 AICP and/or ISP services. ***My signature also attests that I have submitted a copy my client's RWIS consent form to The Health Councils.***

CASE MANAGER'S NAME	AGENCY NAME	PHONE #	FAX #

PLEASE RETURN BY MAIL OR FAX TO

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