THE HEALTH COUNCILS INC.
We Make Health Care Better

REVISED FORM – September 09

# INSURANCE SERVICES PROGRAM
# REQUEST FOR ENHANCED BENEFITS

**Date of Enhanced Benefits Request**: _____

(**Please Note Benefit Levels:** Access to enhanced benefits is limited to $300 per client; however, exceptions may be made if circumstances warrant it. No client is guaranteed access to enhanced benefits. Access to enhanced benefits is subject to the availability of funds.

My client _____ RWIS # _____ is either enrolled in the *Insurance Services Program* administered by The Health Councils, Inc., *or* he/she is wait-listed for program services.

□ I have submitted a copy of my client's RWIS consent form to The Health Councils, Inc.

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

My client earns income less than or equal to 400%FPL: □ **Yes** □ **No**

The last documented date on which I had contact with my client was: _____

| **ENHANCED BENEFITS REQUEST** | | | |
|---|---|---|---|
| **DEDUCTIBLE OR CO-INSURANCE PAYMENT** | | **PRESCRIPTION DRUG CO-PAYMENTS** | |
| **AMOUNT REQUESTED:** | **$** | **AMOUNT REQUESTED:** | **$** |
| **PROVIDER OR INSURANCE COMPANY NAME:** | | **PHARMACY NAME:** | |
| **ADDRESS:** | | **ADDRESS:** | |
| **Coverage Period:** | | **FAX NUMBER:** | |
| **Policy Number:** | | | |

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 submitted a copy my client's RWIS consent form to The Health Councils.***

**CASE MANAGER'S SIGNATURE** **AGENCY** **PHONE #** **FAX #**

**PLEASE RETURN BY MAIL OR FAX TO:**
**The Health Councils, Inc. Attention: Barbara Hay**
**9600 Koger Boulevard, Suite 221 St. Petersburg, Florida 33702 FAX (727)570-3033**