THE HEALTH COUNCILS INC.
We Make Health Care Better

REVISED FORM – June 11

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 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 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:**	
TAX ID NUMBER* *must be provided if payment is to be made to clinic, lab, private physician or hospital			
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. Attn: Barbara Hay 9600 Koger Blvd - #221 St. Petersburg, FL 33702 FAX (727)570-3033