VERIFICATION OF Insurance BENEFITS

Ryan White Part B Program

I, _____, am accessing services through the Ryan White Part B Program. The United States Government requires verification of insurance or lack thereof.

_____ I state during this verification process that I **DO** have private insurance at this time.(quarterly)

Name of Insurance:_____ Policy Number_____

_____ I state during this verification process that I **DO** receive Medicaid at this time.(quarterly)

State ID Number:_____

_____ I state during this verification process that I **DO** receive Medicare A and B at this time.(yearly)

Medicare Number:_____ Effective Date:_____

_____ I state during this verification process I have Medicare Part D(yearly)

Part D Plan Name:_____ Part D Number:_____

_____I access Ryan White Part C program (yearly)

_____I access NE ADAP (AIDS Drug Assistance Program) (yearly)

_____I am on a patient assistance program for medications/care (yearly)

_____ I access other insurance options (VA, extra policies, IHS)(yearly)
Plan Number:_____

I understand that it is my responsibility to report any change in any of the above within 10 business days after receiving verification such change (copy of new card or approval of benefit).

I verify that all statements regarding my insurance coverage (or lack thereof) are true and that this Verification of Benefits Statement must be verified and completed with my Case Manager every 3 months. If my insurance changes I must complete a new Verifications of Insurance Benefits form with my case manager.

Signature: _____ Date:_____
Applicant

Witness: _____ Date:_____
Case Manager

Those denoted as yearly must have form completed one time a year. Those denoted as quarterly must have client sign one time a year and must review with client quarterly.

Reviewed By:

Case Manager: _____ Date:_____
Case Manager

Case Manager: _____ Date:_____
Case Manager

Case Manager: _____ Date:_____
Case Manager