SC ADAP CHANGE OF BENEFIT FORM

D H E C
PROMOTE PROTECT PROSPER

Return to:
SC Drug Assistance Program/
Insurance Assistance Program
3rd Floor, Mills Jarrett
Box 101106, Columbia, SC 29211
PH: (803) 898-0829 or (877) 606-8498
FAX: (803) 898-7683

FOR ADAP USE ONLY - DO NOT WRITE IN THIS SPACE
Date Received: _____ Status/Date: _____
Final Status/Date: _____
Completed by: _____

I. ENROLLEE INFORMATION

Last Name: _____ First Name: _____ Full Middle Name: _____

Month/Year of Birth: ____/XX/_____ Last 4 of SSN: XXX-XX-_____ ADAP ID: _____

II. BENEFIT INFORMATION

Please complete the information below when an enrollee currently enrolled in the Direct Dispensing Program (DDP) acquires health insurance and is applying for assistance with health insurance premiums and/or copays from the Insurance Assistance Program (IAP).

In order to complete the enrollment change without submitting a new application, all information below is required:

A. Applying for: ○ Insurance Copay ○ Insurance Continuation/Health Insurance Premium (HIP)

B. Coverage type:
- ○ Employer-sponsored coverage
- ○ COBRA
- ○ Affordable Care Act (ACA)/Marketplace
- ○ Other _____

C. Premium amount (health coverage for enrollee only). ***Proof of the premium amount must be attached*.***

Medical: $_____ Smoking: $_____ Total: $_____

* Acceptable documentation for proof of premium includes:
- An insurance card stating the insurance effective date AND proof of payment to the insurance company.
- An agency statement with the effective date of coverage AND proof of payment to the insurance company.
- An invoice from the insurance company.
- Certification of the effective date of coverage AND the check number for the payment to the insurance company.
- Enrollment summary from healthcare.gov.
- COBRA enrollment notification/verification.

D. Insurance company/carrier name: _____

E. Insurance company phone number: _____

F. Plan name (Bronze, Silver, Gold) if ACA policy: _____

G. Targeted effective date for coverage to begin: _____

H. End date of coverage, if applicable, i.e., COBRA: _____

_____ _____
Case Manager or Physician (Print Name) Date

_____ _____
Organization (Please print) Phone

Instructions for Completing
SC ADAP INSURANCE ASSISTANCE PROGRAM (IAP)
CHANGE OF BENEFIT FORM

Purpose: This form will be used to switch enrollees to a different service tier within ADAP.

Instructions:

I. Enrollee Information

Name: Enter the enrollee's Last, First, and Full Middle Name.
Date of Birth: Enter the enrollee's Month and Year of birth.
Social Security Number: Enter the last four digits of the enrollee's Social Security Number.
ADAP ID: Enter the enrollee's ADAP ID, if available.

II. Benefit Information

A. Select Insurance Copay if enrollee needs assistance with copays and deductibles or Insurance Continuation/Health Insurance Premium (HIP) if enrollee needs assistance with health insurance premiums. Select both if enrollee needs assistance with both service tiers.

B. Select the appropriate coverage type.

C. Enter the medical premium amount, the smoking charge, and the total amount of the premium payment (health coverage only, for enrollee only).

D. Enter the name of the insurance company/carrier.

E. Enter the phone number of the insurance company.

F. Enter the plan name (Bronze, Silver, Gold) if Affordable Care Act (ACA) policy.

G. Enter the targeted effective date for coverage to begin as indicated from the insurance company.

H. Enter the end date of coverage, if applicable, i.e., if COBRA.

Enter the Case Manager or Physician name, date signed, organization and phone number.

Office Mechanics

Protected Health Information: This form contains Protected Health Information (PHI) and should be stored and/or disposed in accordance with the Provider's privacy policy. Appropriate forms of storage include but are not limited to: 1) in imaged format and secured in the electronic health record (EHR) system, 2) in paper format in each enrollee's secure chart/file, 3) shredded in accordance with your organization's privacy policy. This record of disclosure must remain available for a six (6) year retention period.

Completed change of benefit forms must be submitted into Provide Enterprise by Case Manager or mailed / faxed to:

SC Drug Assistance Program/Insurance Assistance Program
3rd Floor, Mills Jarrett
Box 101106
Columbia, SC 29211

FAX: (803) 898-7683