Important Information Regarding Prescription Coverage and/or Insurance Premium Assistance

Please keep this document in a safe place!

Client ID #:_________________________ Eligibility End Date:________________________

Enrollment Worker's (EW's) Name:___________________ EW's Phone #_______________

Enrollment Site Name/#:____

Maintaining Eligibility

Annual re-enrollment due by: _______________

Bi-annual recertification due by: __________________

Annual re-enrollment: Happens every year on your birthday. Approximately 45 days before your birthday, you will receive a letter in the mail from the California Department of Public Health (CDPH) reminding you to meet with your enrollment worker to complete the re-enrollment process.

Bi-annual recertification: Happens every year six months after your birthday. Approximately 45 days before your recertification due date you will receive a Self-Verification Form (**SVF**) in the mail from CDPH. Follow the instructions on the form to recertify.

If enrolled in OA HIPP, you will be required to submit your most recent billing statement at both Annual re-enrollment and your six-month Recertification.

Program Names

The California Department of Public Health (CDPH) will refer to our programs as Medication Assistance Program and Insurance Assistance Program in order to protect your privacy.

Medication Assistance Program refers to the AIDS Drug Assistance Program (**ADAP**) that helps pay copays or the cost of your medications.

Insurance Assistance Program refers to the programs that pay insurance premiums,

MDPP: Medicare Part D Premium Payment (MDPP) Program,

HIPP: Office of AIDS, and Health Insurance Premium Payment (OA-HIPP) Program

EB-HIPP: Employer Based Health Insurance Premium Payment (EB-HIPP) Program

MOOP (Medical Out-of-Pocket) Expenses: If you are enrolled in an Insurance Assistance Program, you are eligible to have outpatient expenses that count towards your insurance plan's out of pocket maximum paid for by CDPH.

What to Look for in the Mail

Sample SVF

SELF-VERIFICATION FORM (SVF)

Date: ______________ Client ID #: ______________

Dear Client,

Your eligibility for the prescription and (if applicable) insurance assistance program will end on: ____/____/____. Follow the steps below to complete and return this form before the expiration date. If you do not complete this form, you risk being dis-enrolled from the program that pays for your medications and (if applicable) health insurance costs.

STEP 1– REVIEW AND VERIFY YOUR ELIGIBILITY INFORMATION

The most current information in our database is listed below ↓↓↓

			Is the information correct?
A	Residential address or living situation *(your mailing address may be different)*		☐ Yes ☐ No
B	Current annual household income	$ *If your household income has changed but it is still within the program income eligibility limits, please mark "Yes". See income table on the back of this form.*	☐ Yes ☐ No
C	Health Insurance Coverage		☐ Yes ☐ No

If you are a Health Insurance Premium Payment (HIPP) client: You must submit a copy of your most recent health insurance billing statement along with your completed SVF. **If you do not submit a copy of your most recent health insurance billing statement, your insurance assistance may be canceled.** If you are enrolled in Medicare Part D, you do not need to submit a billing statement.

STEP 2– RETURN THE SELF-VERIFICATION FORM

If you answer "YES" to box 'A', 'B', and 'C' above : (1) Read the *Client Acknowledgement* below; and **(2)** Return this completed form by mail to SVF Processing Center, 4660 S. Hagadorn Rd. Suite 290, East Lansing, MI 48823, using the pre-paid envelope provided. You can also return the form to your Enrollment Worker/enrollment site before your eligibility end date highlighted at the top of this page.

If your answer is "NO" to box 'A', 'B', and/or 'C' above: Do Not Return This Form by Mail. You must contact your Enrollment Worker/enrollment site to complete your eligibility recertification process before the eligibility end date highlighted at the top of this page. Take this form and your supporting eligibility documentation with you when you meet with your Enrollment Worker.

Client Acknowledgement

I am providing information on this form to continue my eligibility for the program. I understand that I may be denied program services if I have given false information or if I fail to give complete information by the eligibility end date above. By signing below, I certify, to the best of my knowledge, the information provided is true and correct.

Client Name (print): ______________________________

Client Signature (required): ______________________________ **Date:** ____/____/____

If you have questions or need help completing this form, please contact your Enrollment Worker. Or you can contact a representative at 1-844-550-3944. More information can be found at CAMEDAssist.org.

Annual Renewal Letter:

State of California—Health and Human Services Agency
California Department of Public Health

Karen L. Smith, MD, MPH
Director & State Health Officer

EDMUND G. BROWN JR.
Governor

Dear Client:

Your prescription coverage is ending soon. Please contact your enrollment worker by <Orig Eligblty End Dt> to renew your eligibility. You will need to meet with your enrollment worker to submit all of the required documentation in order to reassess your eligibility for the medication assistance program and (if applicable) health insurance assistance program. If you do not know your enrollment workers contact information, please call our Customer Service at 844-421-7050.

Su cobertura de recetas médicas finalizará pronto. Comuníquese con encargado de las inscripciones antes del <Orig Eligblty End Dt> para renovar su elegibilidad. Deberá reunirse con el encargado de las inscripciones para presentar toda la documentación necesaria a fin de de reevaluar su elegibilidad para el programa de asistencia de medicamentos y (si corresponde) el programa de asistencia de seguro de salud. Si no tiene la información de contacto del encargado de las inscripciones, comuníquese con nuestro Servicio de Atención al Cliente al 844-421-7050.

您的處方承保即將結束。請在[7/9/2018 之前聯絡您的註冊入保工作人員。。以更新您的資格您將需要與入保工作人員會面 提交所，，有必需的文件 以重新評估您的藥物援助計劃和（如適用）健康保險援助計劃的資格。若您不清楚入保工作人員的聯絡資訊，請致電我們的客戶服務部：844-421-7050。

Ang iyong coverage sa inireresetang gamot ay malapit nang magtapos. Mangyaring makipag-ugnayan sa iyong enrollment worker hanggang 7/9/2018 upang i-renew ang iyong pagiging karapat-dapat. Kakailanganin mong makipagkita sa iyong enrollment worker upang isumite ang lahat ng kinakailangang dokumento upang muling matasa ang iyong pagiging karapat-dapat para sa programang tulong sa gamot at (kung naaangkop) programang tulong sa segurong pangkalusugan. Kung hindi mo alam ang impormasyong pangkontak sa iyong enrollment worker, mangyaring tawagan ang aming Serbisyo sa Kostumer sa 844-421-7050.

Magellan Rx Card for Pharmacy and Medication Benefits (ADAP)

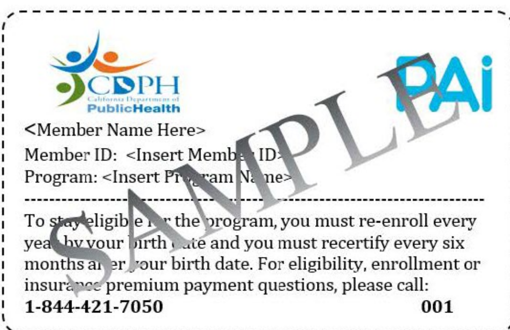
RxBIN #: 018786
RxPCN #:
RxGrp #: RX222327
Issuer: (80840)
Member ID #:
Member Name:

For pharmacy and medication billing questions, please call Magellan Rx Management at 1-800-424-5906.

To maintain your coverage in the program, you must re-enroll every year by your birth date and recertify every year six months after your birth date. If there is a change in your income, residency, or insurance, or if you have any questions about your program enrollment or eligibility, please contact your local enrollment worker or call CDPH at 1-844-421-7050.

Magellan Rx Management |11013 W. Broad Street, Suite 500 | Glen Allen, VA 23060

PAI card for Insurance Premiums and MOOPS
(Clients will only receive this card if enrolled in an Insurance Assistance Program)*



<Member Name Here>
Member ID: <Insert Member ID>
Program: <Insert Program Name>

To stay eligible for the program, you must re-enroll every year by your birth date and you must recertify every six months after your birth date. For eligibility, enrollment or insurance premium payment questions, please call:
1-844-421-7050 **001**

SAMPLE

To Providers: This member is enrolled in a California Department of Public Health, health insurance assistance program. Please call **1-877-495-0990** to establish automated payments. Or, submit a claim and supporting documentation using one of the following methods:

1. Electronically: Payer ID: AI0
2. Fax: (860) 560-3125
3. Email: CDPH-MBM-Fax@pooladmin.com
4. Mail: PAI-CDPH, 02, 628 Hebron Avenue, Suite 302, Glastonbury, CT 06033

This card does not guarantee eligibility. Please call the following number during each visit to confirm eligibility:
1-844-421-7050

SAMPLE

**OA-HIPP, MDPP and EB-HIPP*

Contact Information

For enrollment status, program eligibility, or general information questions:

California Department of Public Health (CDPH)
Phone: (844) 421-7050
Fax: (844) 421-8008
Email: CDPHMedAssistFax@cdph.ca.gov
Available Monday- Friday, 8AM – 5PM

For **prescription, pharmacy, drug co-pay**, drug formulary, or pharmacy location questions:

Magellan Rx, Phone: (800) 424-5906
Available 24 hours a day, 7 days a week

For questions about **medical out-of-pocket cost claims and Health Insurance Premiums**:
Pool Administrators Inc., (PAI) Phone: (877) 495-0990
Available Monday - Friday, 8AM - 5PM

PAi