The University of Arizona

Petersen HIV Clinics' Premium Assistance Program

1501 N. Campbell Ave., Box 245039
Tucson, AZ 85724
Phone: (520) 626-8598 · Fax: (520) 626-6352

Patient Eligibility - To participate in Petersen Clinics' Premium Assistance Program the following criteria must be met:

- Patient must be HIV positive and a patient of Petersen Clinic
- Income must fall between 138% and 400% of the FPL (documentation required)

Patient Contract - By signing this form, I hereby agree to the following:

- To consult with a Medicare Shoppe agent regarding my health insurance options
- For Petersen Clinic staff to communicate with members of my care team, including those who are affiliated with the purchase of my health insurance and those providing financial assistance, as necessary and with the intent to facilitate access to medical services
- To maintain communication with my medical case manager at the Petersen Clinic regarding my health insurance coverage and financial support related to my medical care and medications
- To ask my primary care physician to issue a referral for specialty care at the Petersen Clinic if indicated by my medical case manager
- To seek medical services within the Banner Health Network as a Pima County Resident and to discuss medical service options with my medical case manager if I reside outside of Pima County.
- To remain compliant with the Infectious Disease provider's care plan consisting of routine lab work and visits
- To seek prior authorization from the program for outpatient procedures and physical therapy (Contact the Program Administrator at 520.626.5114)
- To renew my enrollment, and provide documentation of income, every 12 months
- To inform Petersen Clinic of any life changing events within 3 business days (i.e. change of employment, healthcare coverage, address, income, household size, etc.)

I understand this program will only provide financial support for costs associated with outpatient medical care and that support is contingent upon available funding. By signing this contract, I acknowledge these terms. **If the above requirements are not met, Petersen Clinics will not be responsible for paying your premiums and your insurance plan may be terminated. Petersen Clinics are not responsible for terminating any previous insurance plans.**

Client Name	**Client Signature**	**Date**

Last Name: ____________________________ **First:** ____________________________ **M.I.** ______________

Nick Name: ___________________________ **SS No:** _____-____-_____ **Date of Birth:** ____/____/____

Address: ____ **Mail: Yes** ☐ **No** ☐ **Discrete** ☐

City: ________________________________ **State:** ______ **Zip:** _________ **County:** ___________________

Phone: ___________________________________ **Email:** ____

Monthly Income: _________________________ **Household Size:** __________________________________

Documents Included:

☐ Proof of income (pay stubs, tax return, bank statements, etc.)

For Department Use Only: ☐ **New** ☐ **Renewal** ☐ **Denied - Reason:** __________________________

Approval by: _____________________ **Date:** __________ **Plan Dates:** ___________ **to** ____________

The University of Arizona

Department of Medicine, Petersen HIV Clinics
Premium Assistance Program

Cap on Charges for Specialty Services

Specialty services are available to Petersen Clinics' Premium Assistance Program participants as a component of comprehensive HIV medical care at the University of Arizona's Petersen HIV Clinics.

Specialty services include, but are not limited to:

Neurology	Gynecology	Pathology/Cytology	Physical Therapy	Oncology	Urology
Gastrology	Radiology	Dermatology	Ophthalmology	Pulmonary	

Specialty referrals can be arranged through an appointment with your Petersen Clinic or primary care physician. Services include office visits, laboratory, diagnostics, and outpatient procedures. Financial support for inpatient services is **NOT ALLOWABLE** under the Petersen Clinics' Premium Assistance Program.
**NOTE: outpatient procedures and physical therapy require prior authorization from the program. Please contact the program administrator (52) 626-5114 for details.*

The Petersen Clinics' Premium Assistance Program provides financial support for specialty services up to $3,000 per year. Service costs beyond $3,000 are subject to funding availability and will be reviewed on an individual basis.

If your specialty care exceeds $3,000, please obtain a signed and dated cost estimate from your specialty provider and submit, with your name and contact information, to the Petersen Clinics' Premium Assistance Program Administrator by mail at 1501 N. Campbell Ave, P. O. Box 245039 Tucson, AZ 85724-5039 or by fax at (520) 626-6352. The Program Administrator will contact you with a response within 5 working days of the submission date.

By signing below, I acknowledge that I have read and fully understand the level of specialty services available to me through the Petersen Clinics' Premium Assistance Program.

____
Patient's Printed Name

____ ____________________
Patient's Signature Date

____ ____________________
Program Administer's Signature Date

3503 E Hardy Drive
Tucson, AZ 85716
Phone: 520-812-7908
Fax: 520-325-9743

I, ___________________________________, by signing this form authorize The Medicare Shoppe/Thrive Co-Pay Assistance Program and associated Licensed Agents or staff permission to aid with the purposes of obtaining health insurance coverage online through the Healthcare.gov website.

I understand that if I do not have a Heatlhcare.gov and/or email address account one will need to be created for me and I allow the parties listed above to act on my behalf in creating the necessary accounts.

I understand that I must provide accurate information to The Medicare Shoppe/Thrive Co-Pay Assistance and I cannot hold these organizations, their Licensed Agents or their staff responsible if I fail to provide accurate information or fail to update my information as required by Healthcare.gov, CMS or the Health Insurance Carrier I choose.

I understand that The Medicare Shoppe/Thrive Co-Pay Assistance must speak to me directly before they can select and enroll me into a health plan. If I fail to respond or answer their calls, I understand I will not be enrolled into a health plan until I verbally verify my enrollment choice.

I understand that the Insurance Carriers participating on Healthcare.gov do not pay Licensed Agents a commission and that they will not have access to my information including my member ID. I agree to communicate this information back to the Licensed Agents if I qualify for Thrive Co-Pay Assistance Programs cost sharing assistance/premium program.

Signature: ____

Date: ____

3503 E Hardy Drive
Tucson, AZ 85716
Phone: 520-812-7908
Fax: 520-325-9743

I, ___________________________________, by signing this form authorize The Medicare Shoppe/Thrive Co-Pay Assistance Program and its Licensed Agents or staff permission to assist me with the Healthcare.gov site. The Information I provide below is accurate to the best of my knowledge.

Name: ____

Address: ____

Phone: ____

Date of Birth: ____

Social Security Number: ____

U.S. Citizen: ________________ **If No Resident/Alien #:** ___________________________

Employer: ______________________________ **Employer Phone #:** _________________

Monthly Income: ____

Other Income: ____

Dependents: ____

Do you Smoke? ____

Signature: ____________________________________ **Date:** ______________________

If there are dependents we will need the same forms filled out on each dependent including your spouse and any children, you claim on your tax returns even if they are not applying for coverage.

3503 E Hardy Drive
Tucson, AZ 85716
Phone: 520-812-7908
Fax: 520-325-9743

The Medicare Shoppe/Thrive Co-Pay Assistance Program
AUTHORIZTION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

By completing this form I am giving permission, and hereby request, the selected protected health information below to be released to The Medicare Shoppe and/or Thrive Co-Pay Assistance Program including all employees, Licensed Agents, contractors, and associated individuals within these organizations for purposes of care coordination.

This authorization is limited to the following release of protected health information:

Initial applicable (PHI) release request:

______ All my records including health plan member ID

______ Pharmacy information

______ Prior authorization

______ Claims/Explanation of Benefits

______ Health Plan Annual Out of Pocket

______ Itemized billing statements for copay assistance purposes.

______ Premium billing/ payment information

______ Preventative care as well as diagnosis & treatment of chronic and acute conditions

______ Health Plan Member ID

By signing this form, I understand the selected protected health information initialed above will be released to The Medicare Shoppe and/or Thrive Co-Pay Assistance Program including all employees, Licensed Agents, contractors, and associated individuals within these organizations for care coordination purposes.

Member Name: ____

Member Date of Birth: ____

Member Social Security #: ____

Member Mailing Address: ____

Members Phone Number: ____

Signature of Member: ____________________________________Date: ____________

This authorization of (PHI) release will not expire unless we receive in writing your request in which you may revoke this authorization at any time in writing by sending it to The Medicare Shoppe/Thrive Co-Pay Assistance Program 3503 E. Hardy Drive, Tucson AZ 85716.

MEDICAL RECORDS RELEASE

THIS MEDICAL RECORDS RELEASE (the "Release") is made ____________/__________,20_______.

TO: The Medicare Shoppe, 3503 E. Hardy Drive, Tucson, AZ, USA, 85716, Phone: (520) 812-7908, Fax: (520) 325-9743 and all employees, contractors, and associated individuals thereof;

TO: Thrive Co-Pay Assistance Program, 3503 E. Hardy Drive, Tucson, AZ, USA, 85716, Phone: (520) 812-7908, Fax: (520) 325-9743 and all employees, contractors, and associated individuals thereof;

TO: Department of Medicine-Petersen Clinics, PO BOX 245039, Tucson, AZ, USA, 85724, Phone: (520) 694-8888, Fax: (520) 626-6352 and all employees, contractors, and associated individuals thereof;

TAKE NOTICE THAT I, ____(the "Patient"), do hereby request the following information be released:

Medical Records

1. All medical and health information contained within:

   a. Charts;

   b. Notes;

   c. Reports;

   d. Records;

   e. Medication lists, and other lists;

   f. Prescriptions;;

   g. Flowcharts;

   h. Emails;

i. Memorandum;

j. Orders;

k. Lab results;

l. Test results, and analysis;

m. Information related to treatment for any sexually transmitted disease, including HIV or AIDS;

n. Information related to treatment for mental health illnesses;

o. Information related to treatment for substance abuse;

p. Diagnostic images and reports, including but not limited to X-Rays and EKG tracings;

q. Photographic images; and

r. Digital recordings, including but not limited to digital images.

1.2 All information related to the accounting of the Patient's files, including but without limitation to Statements of Account.

1.3 All other authorizations previously received for the release of any or all of the Patient's medical information.

1.4 All of the above is collectively referred to as "Medical Records", as represented on paper, kept in folders, digitally, electronically, or any other form.

1.5 "Medical Records" also includes production of any documents or material by physicians, nurses, chiropractors, dentists, therapists, counselors, consultants, technicians, and any and all staff of the organization to which this Release is directed.

Disclosure

2. I ask that the Patient's Medical Records be released to me, for my own personal use.

Time

3. I ask that the Patient's Medical Records be released within the next 30 days as required by the *Health Insurance Portability and Accountability Act.*

Notice and Additional Information

4. The contact information and particulars of the Patient are as follows:

Name: ______________________

Date of Birth: ______________________

Street Address: ______________________

City/Town: ______________________

State: ______________________

Country: ______________________

Postal/ZIP: ______________________

Home Phone Number: ______________________

Cell Phone Number: ______________________

Email: ______________________

Duration of Medical Records Release

5. This Release will be valid until such time that you receive written notice from me revoking this Release.

Continuance of Ongoing or Future Care

6. This Release does not affect any ongoing or future care of the Patient.

SIGNED at ______________________, Arizona in the presence of:

______________________ WITNESS

______________________ PATIENT/LEGAL REPRESENTATIVE