DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-01423 (12/2019)

STATE OF WISCONSIN
HIV Program
ADAP

HIV DRUG ASSISTANCE AND INSURANCE ASSISTANCE PROGRAM INSURANCE ENROLLMENT REPORT

CONTACT INFORMATION

Last Name	First Name	Birth Date (mm/dd/yyyy)

Case Manager Name	Case Management Agency

SECTION 1: INSURANCE INFORMATION
Check the box that best describes your situation.

I have enrolled in (a):

- ☐ BadgerCare
- ☐ **Silver Plan** through the Marketplace
- ☐ Insurance through my employer
- ☐ COBRA
- ☐ Part D plan
- ☐ Medicare Supplement Plan
- ☐ Medicaid Purchase Plan (MAPP)
- ☐ None of the options

SECTION 2: INSURANCE POLICY INFORMATION
Please be as complete as possible. Contact your insurance company for this information if needed.

IMPORTANT NOTE: Please attach any documents relevant to your insurance coverage. This may include a payment coupon book, insurance invoice, or printout from the marketplace showing premium and tax credit amounts. Use the additional policy section if you have more than one premium that needs to be paid.

Insurance Policy Information

Insurance Company

Mailing Address for Payment		City, State, Zip Code
Policy Start Date	**Policy End Date**	**Policy Number**
Payment Amount	**Due Date (do not use ASAP)**	**Payment is Made** ☐ Monthly ☐ Quarterly ☐ Annually

Additional Policy (Dental, Medicare Supplement, etc.)

Insurance Company

Mailing Address for Payment		City, State, Zip Code
Policy Start Date	**Policy End Date**	**Policy Number**
Payment Amount	**Due Date (do not use ASAP)**	**Payment is Made** ☐ Monthly ☐ Quarterly ☐ Annually

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