BENEFIT CHANGE FORM

SOUTH CAROLINA DEPARTMENT OF PUBLIC HEALTH

Return to:
SC Drug Assistance Program
3rd Floor, Mills Jarrett
Box 101106
Columbia, SC 29211

FOR INTERNAL 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- _____ DAP ID: _____

II. BENEFIT INFORMATION

Please complete the information below when an enrollee currently enrolled in the SC Drug Assistance Program needs to be switched to a different service tier or there is a change in insurance.

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

A. Enrollee is currently enrolled in: ☐ DDP ☐ IAP ☐ MAP

B. ☐ **Switch to DDP** - Choose when enrolled in either MAP or IAP and has lost coverage. *No documentation is required.*

- Reason for switch*: ☐ Lost Insurance ☐ Lost Medicare Coverage ☐ Other: _____
- If client lost Medicare Coverage, please select an approved reason*:

☐ Non-payment of Premiums ☐ Did not report earned wages to SSA ☐ Fraud
☐ Incarcerated-Pretrial Detainee ☐ Payment Issue ☐ Disability Ended ☐ Lost Extra Help
☐ Unable to afford penalty for non-enrollment ☐ Returned to work ☐ Relocated and out of network

*** Required**

C. ☐ **Switch to MAP** - Choose when enrolled in either IAP or DDP and gets Medicare Part D coverage. *Requires Medicare D documentation.*

Medicare:

- Social Security Benefit Mailing Zip*: _____ - _____
- Effective date(s) if Medicare Part A or Part B is Active: Part A: _____ Part B: _____
- Medicare Part D (Medication) Status*: ☐ Active ☐ Applied (Date applied _____) ☐ Not eligible
- Medicare Part D Carrier: _____
- Medicare Part D Plan: _____
- Enrollment Start Date: _____ Enrollment End Date: _____
- Medicare Part D Member ID*: _____
- Medicare Part D LIS Status*: ☐ Active ☐ Applied (Date applied _____) ☐ Not eligible ☐ Denied
- Medicare Part D FLIS Status*: ☐ Active ☐ Applied (Date applied _____) ☐ Not eligible ☐ Denied
- LIS/FLIS Not Eligible, please select reason: ☐ Income too high ☐ Assets too high ☐ Spend down required
  ☐ Required waiting period ☐ Referring pension and other benefits
  ☐ Incarcerated-Pretrial ☐ Unable to recertify for FLIS
  ☐ Returned to work

Documentation*:

- Extra Help (LIS/FLIS) Approval/Denial Letter or proof of application for Extra Help (LIS/FLIS), if income is below 150% of FPL

*** Required**

D. ☐ **Switch to IAP** – Choose when enrolled in either MAP or DDP and loses Medicare D coverage or gains insurance; because of a change in the insurance plan or carrier; or to enroll or dis-enroll in the Premium Assistance program.

Also applying for Premium Assistance? ☐ Yes ☐ No

Insurance Policy (Attach insurance card if available)**:**

- Benefit change is occurring*: ☐ After initial payment is sent to/received by insurer
  ☐ After the initial invoice is received from the client/insurer
  ☐ After coverage begins and the insurance card is available

- Primary Private insurance status: ☐ Active ☐ Applied ☐ Available ☐ Not eligible

- Coverage type*: ☐ ACA ☐ Employer ☐ COBRA ☐ Private

- Coverage start date*: _____ Coverage end date: _____

- Private carrier*: _____
- Private insurance plan*: _____
- Private insurance group: _____
- Insurance subscriber ID: _____

*** Required**

Premium Assistance *(Complete only if applying for Premium Assistance)***:**

- Medical/Rx Premium*: _____
- Smoking Premium*: _____
- Premium Amount*: _____

*** Required**

Documentation*:

- Proof of premium amount – *Attach if applying to the Premium Assistance Program*

*** Required**

E. ☐ **Indicate a change for an IAP enrollee** – Choose when enrollee is enrolled in IAP and there is a change in the insurance plan or carrier or to enroll or dis-enroll in the Premium Assistance program.

☐ Change of Plan or Carrier – For IAP enrollees not enrolled in Premium Assistance. Complete section D. Insurance Policy. *No documentation is required.*

☐ Insurance Premium or Plan/Carrier Update – For IAP enrollees currently enrolled in Premium Assistance. Complete section D. Insurance Policy and Premium Assistance. *Attach proof of premium.*

☐ Enroll in Premium Assistance – Complete section D. Insurance Policy and Premium Assistance. *Attach proof of premium.*

☐ Remove from Premium Assistance. *No documentation is required.*

Instructions for Completing 1543-ENG-DPH
BENEFIT CHANGE FORM

Purpose: This form will be used to switch enrollees to a different service tier within the SC Drug Assistance Program (DAP).

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.
DAP ID: Enter the enrollee's ADAP ID, if available.

II. BENEFIT INFORMATION

A. Indicate the service tier the enrollee is currently enrolled in.

B. **Switch to DDP:** Choose when enrolled in either MAP or IAP and has lost coverage. *No documentation is required.*
- *Reason for Switch*:* Select reason for switch.
- *If client lost Medicare Coverage, please select an approved reason*:* Select reason for switch.

C. **Switch to MAP:** Choose when enrolled in either IAP or DDP and gets Medicare Part D coverage. *Requires Medicare D documentation.*

Medicare:

- *Social Security Benefit Mailing Zip*:* Enter the social security benefit mailing zip code.
- *Effective date(s) if Medicare Part A or Part B is Active:* Enter the effective date(s).
- *Medicare Part D (Medication) Status*:* Select the status.
- *Medicare Part D Carrier:* Enter the name of the carrier.
- *Medicare Part D Plan:* Enter the name of the plan.
- *Enrollment Start and End Date:* Enter the start and end dates.
- *Medicare Part D Member ID*:* Enter the member ID number.
- *Medicare Part D LIS Status*:* Select the status.
- *Medicare Part D FLIS Status*:* Select the status.
- *LIS/FLIS Not Eligible:* Select the reason.

* Indicates a required field.

Documentation*: Extra Help (LIS/FLIS) Approval/Denial Letter or proof of application for Extra Help (LIS/FLIS), if income is below 150% of FPL

* Indicates a required field

D. **Switch to IAP** – Choose when enrolled in either MAP or DDP and loses Medicare D coverage or gains insurance; because of a change in the insurance plan or carrier; or to enroll or dis-enroll in the Premium Assistance program.

Also applying for Premium Assistance? Indicate if enrollee is applying for Premium Assistance or not.

Insurance Policy (Attach insurance card if available)**:**

- *Benefit change is occurring*:* Select when benefit change is occurring.
- *Private insurance status:* Select the status.
- *Coverage type*:* Select the type of coverage.
- *Coverage start and end date*:* Enter the start and end dates.

- *Private carrier*:* Enter the name of the carrier.
- *Private insurance plan*:* Enter the name of the insurance plan.
- *Private insurance group:* Enter the name of the insurance group.
- *Insurance subscriber ID:* Enter the subscriber ID number.

* Indicates a required field

Premium Assistance:

- *Medical/Rx Premium*:* Enter the medical/Rx premium amount.
- *Smoking Premium*:* Enter the smoking premium amount.
- *Premium Amount*:* Enter the total premium amount.

* Indicates a required field

Documentation*: Proof of premium amount – Attach if applying to the Premium Assistance Program

* Indicates a required field

E. **Indicate a change for an IAP enrollee** – Choose when enrollee is enrolled in IAP and there is a change in the insurance plan or carrier or to enroll or dis-enroll in the Premium Assistance program.

- *Change of Plan or Carrier* – For IAP enrollees not enrolled in Premium Assistance. Complete section D. Insurance Policy. No documentation is required.
- *Insurance Premium or Plan/Carrier Update* – For IAP enrollees currently enrolled in Premium Assistance. Complete section D. Insurance Policy and Premium Assistance. Attach proof of premium.
- *Enroll in Premium Assistance* – Complete section D. Insurance Policy and Premium Assistance. *Attach proof of premium.*
- *Remove from Premium Assistance.* No documentation is required.

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 Benefit Change forms must be submitted into Provide Enterprise by Case Manager or mailed to:

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