

Clear Form

**MICHIGAN DRUG ASSISTANCE PROGRAM (MIDAP)
INTERIM MEDICATION FORM**

This form must be received and processed by MIDAP in order for applicant to be eligible to pick up medications. Please call MIDAP to confirm receipt.



FY2013

Subscriber ID/Member ID (found on SGRX/MIDAP Card, if applicable)

Last Name First Name Middle Initial

Address Please Note: All MIDAP related information will be sent to this address

City State Zip Code Phone Number

County Social Security Number Birthdate

Gender* : Female Male Transgender
Are You Pregnant?: No Yes
If yes, What is your due date?
Transgender Status: Female to Male Male to Female

PLEASE READ AND COMPLETE ALL SECTIONS -Incomplete applications and/or missing information will not be accepted and/or will delay processing.

Race/Ethnicity* (Check all that apply):

- Hispanic/Latino
- Black or African American White
- American Indian or Alaska Native Asian
- Pacific Islander/Native Hawaiian Unknown

Please Answer the Following Questions*:

- Are you a Resident of the State Of Michigan? Yes No
- Are You Homeless? Yes No
- Do You Have any type of Insurance? Yes No
- Do you have or are you eligible for Medicare? Yes No

Reason for request (check all that apply and/or write in additional details):

- Being discharged from hospital
- Medicaid/Adult Medical Program Coverage ended/cancelled
- Lost Private Insurance/COBRA
- Recently Moved to Michigan
- Other, Please Explain -

I have referred to the Michigan Drug Assistance Program Eligibility criteria and have determined that this individual is eligible for service and that the financial and other information necessary to make this decision is available for review in agency files. I also verify by my signature below that the medications to be billed to MIDAP are on the current MIDAP formulary.

Case Manager Signature Date

Case Manager Printed Name Agency Name

Phone Number Fax Number

I authorize MIDAP to receive, disclose, and discuss medical/dental information related to the care and treatment of my HIV infection with any health insurance or government health insurance program, or other individuals as required and necessary. .

I understand that the information I have provided on this application will be shared with other government agencies, health insurance companies and/or the contracted pharmacy benefits manager for the purpose of verifying the accuracy of the information provided and in determining my eligibility for MIDAP and/or other programs that I may be eligible for.

Applicant Signature Date

FAX TO THE MIDAP OFFICE AT 517-335-7723

MIDAP OFFICE USE ONLY

- Not on MIDAP Currently BRIDGES NONE PENDING DENIED Cov.BegDate
- DENIED
- APPROVED Reviewed by MIDAP ID Cov.EndDate