



**AUTHORIZATION FOR RELEASE OF INFORMATION**

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.

I understand that if I become enrolled in a health insurance program with prescription coverage and/or dental coverage or if I qualify for medical assistance through other federal, state or county medical benefit programs, I must immediately notify the Michigan Department of Community Health, Drug Assistance Program (MIDAP) and Michigan Dental Program (MDP) in addition to my pharmacist, and physician.

I understand and agree to submit periodic information regarding my continued eligibility for MIDAP/MDP, including proof of income, proof of residency, health insurance coverage, and general updates on forms provided by the MIDAP/MDP. I understand that changes in my situation will be evaluated to determine my continued eligibility for MIDAP/MDP. I will be notified in writing if I am to be discontinued from MIDAP/MDP.

I understand that I must annually, or as required to fulfill funding requirements, recertify as eligible for MIDAP/MDP to receive assistance with my medications and/or dental care. I understand that if I submit an application that is determined to be incomplete in fulfilling the requirements for approval that I will not be eligible for assistance until all the requirements are met.

I understand that if any of the information provided on this application changes that I must notify the MIDAP/MDP immediately. In addition, I understand that failure to report changes and/or reporting of inaccurate information will affect MIDAP/MDP coverage and program eligibility.

I understand that by utilizing MIDAP for medication assistance and by filling prescriptions using my SGRX/MIDAP card and/or by accessing dental care that I am agreeing to abide by all MIDAP/MDP policies and procedures. I understand that MIDAP/MDP is not insurance and is not valid outside of the state of Michigan.

The information that I have provided on this application is complete and true to the best of my knowledge. I certify that I meet the eligibility requirements as specified in the instructions and have followed the necessary steps that are required for me to be eligible for the Michigan Drug Assistance Program. This application, when completed, contains patient information that must be protected in accordance with the Health Insurance Portability and Accountability Act.

**AGENCY OR PERSON**

**PHONE NUMBER**

**Case Manager** \_\_\_\_\_

**Dentist** \_\_\_\_\_

**Other** \_\_\_\_\_

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name of Applicant** \_\_\_\_\_

PLEASE MAIL OR FAX APPLICATION AND ANY SUPPORTING DOCUMENTATION TO:

Michigan Dental Program  
109 Michigan Avenue, 9<sup>th</sup> Floor  
Lansing, Michigan 48913  
Phone: (888) 826-6565  
Fax (517) 335-7723

<b>MDP office use only</b>	
<b>Confirmed MDP Coverage:</b>	
<input type="checkbox"/> Medicaid <input type="checkbox"/> Michigan Resident <input type="checkbox"/> Income <input type="checkbox"/> Labs(Proof of Status)	Denied _____ Date __/__/____ Reason Code: _____ Initials _____
Approved _____ Date __/__/____ Initials _____	