



Nevada Ryan White Parts ABCD Common Guidance Document Survey of Existing Insurance Coverage

Date: _____

Client Name: _____ Client DOB: _____

For all forms of health care coverage please supply copies of your benefit cards and information only if insurance or prescription assistance is being requested.

Is Insurance or Prescription Assistance being requested? Yes No

You must make every effort to have and maintain health care coverage. If you are undocumented, you will not qualify for health care coverage and do not need to apply for health care coverage through Nevada Health Link. If you are exempt from enrolling in Health Care Coverage, you will need to provide a certificate of exemption

I _____ currently have insurance through my **Employer** as an active employee.

If yes, complete CGD 15-49

I _____ currently have insurance through Nevada Health Link/Insurance **Marketplace**.

If yes, provide benefits package to Access to Healthcare Network if requesting monthly premium and copayment assistance

I _____ currently have **Medicare Part A/B** (Hospital Insurance/Medical Insurance).

I do/do not currently have a **Retiree Health Plan** from a former employer as secondary insurance, which pays after Medicare pays, and includes prescription drug coverage.

If yes, provide benefits package to Access to Healthcare Network if requesting monthly premium and copayment assistance

I _____ currently have a **Medicare Part D Plan** (Prescription Drug Coverage).

If yes, provide benefits package to Access to Healthcare Network if requesting monthly premium and copayment assistance

I _____ currently have a **Medicare Health Plan** (HMO/PPO/PFFS that includes Prescription Drug Coverage).

If yes, provide benefits package to Access to Healthcare Network if requesting monthly premium and copayment assistance

I _____ currently have **Nevada Medicaid**.

I _____ currently have **Veterans Health Administration** or other military health benefits.

I _____ currently have **Indian Health Service** or other tribal health benefits.

I hereby declare that the above information regarding my insurance status is true.

Client Signature

Date