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| --- | --- |
| **Date Submitted** |  |

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| --- | --- |
| **Name of Client** |  |

|  |  |
| --- | --- |
| **Client Unique ID Number** |  |

|  |  |
| --- | --- |
| **Name of Insurance Provider** | Delta  None  Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
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| Services not covered within $5000 treatment allowance. *Note: Must attach documentation (i.e. treatment plan, including medical necessity).* |  |

|  |  |
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| **Amount of additional dollars** |  |

Please submit to form to [sdeller@health.nv.gov](mailto:sdeller@health.nv.gov)

Please note that these funds are not to be used for

cosmetic or enhancing procedures, upgrades, or implants

**The following is to be completed by the Nevada Office of HIV/AIDS**

**Approved**

**Denied**

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Approved By: Date: