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

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

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

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

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

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

Please submit to form to 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** [ ]

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approved By: Date: