Nevada Office of HIV
Ryan White Part B Program
Nevada Medication Assistance Program
Client Acknowledgement Form

Client Information

Legal First Name: _____ Legal Last Name: _____

Birth Date: _____

Please initial that you understand the following program requirements:

_____ I understand that as a client of the Nevada Medication Assistance Program (NMAP), I will complete my annual certification and re-certification in the time frame established by the Ryan White Program in order to remain eligible for the NMAP.

_____ I understand that failure to complete my annual certification and re-certification in the time frame established by the Ryan White Program may lead to dis-enrollment from the NMAP.

_____ I understand that I must use the Magellan Medicaid Administration, Inc. Insurance Card provided by the program to fill any and all medications that are currently on the NMAP Formulary.

_____ I understand that by enrolling in NMAP (for assistance with health insurance premiums) I must use the NMAP contracted Pharmacy Network. If after two (2) months of not using NMAP's contracted pharmacy network to fill my prescription(s) I will be contacted to ensure that I am still in care.

_____ I understand that after three (3) months of not using NMAPs contracted pharmacy network to fill my prescription(s) I will be choosing to opt-out of my enrollment and services in NMAP. Opting out of NMAP means the program will no longer be able to pay for my insurance premiums and/or the cost of my medications and I may be responsible for the full cost of my medications and/ or insurance premiums.

I fully understand that by completing this form, I am divulging personal information that will be used to assist me with benefits associated with the NMAP. I understand this information will be kept confidential but will be used by staff to review my eligibility for this program.

Client Signature: Date:

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