NEVADA OFFICE OF HIV
RYAN WHITE PART B PROGRAM
NEVADA MEDICATION ASSISTANCE PROGRAM
CLIENT ACKNOWLEDGEMENT FORM
NON-ADVANCE PREMIUM TAX CREDIT

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, I will complete my annual certification and re-certification in the time frame established by the Ryan White Program 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 Medication Administration, Inc. Insurance Card provided by the program to fill all medications that are currently on the Nevada Medication Assistance Program Formulary.

_____ I understand that by enrolling in NMAP (for assistance with health insurance premiums) I must use the NMAP contracted Pharmacy Network. If after three (3) 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 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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