MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

# MICHIGAN DRUG ASSISTANCE PROGRAM (MIDAP)
# PREMIUM ASSISTANCE ADJUSTMENT

Client Name: _____ MIDAP Member ID: _____

Date of Birth: ____/____/____ Social Security Number: _____

Name of Insurance Company: _____

Insurance Account Number and/or Member ID found on billing statement: _____

## Type of Insurance Plan

☐ Qualified Health Plan (Marketplace) ☐ Medicare Prescription Plan (Med D) ☐ COBRA (IAP Plus)

## Reason for Adjustment (Check All That Apply)

☐ My current insurance plan is no longer active effective _____ /_____/ _____. Please stop making payments on my account.

☐ My premium rate has changed effective _____/_____/_____. Please pay the new amount of $_____ on a Monthly/Quarterly basis. (Circle which applies).

☐ My insurance account is past due. The amount due is $_____ for the month(s) of _____/_____/_____ to _____/_____/_____.

☐ My insurance account has a credit in the amount of $_____ as of _____/_____/_____.

- Please attach the most recent invoice from your insurance company that reflects the adjustment requested.
- It is the client's responsibility to keep in contact with the insurance company to verify that a payment was received.

I CERTIFY THIS INFORMATION TO BE ACCURATE AND TRUE:

CLIENT SIGNATURE: _____ DATE: _____/_____/_____

This form, when completed, contains confidential information that must be protected under applicable federal and state confidentiality laws.

Fax or Mail to MIDAP at:

(517) 335-7723
109 W. Michigan Ave, 9th Floor
Lansing, MI 48913

Completion Authority: PA 368 of 1978 is voluntary, but is necessary to receive coverage under the Michigan Drug Assistance Program. Michigan Department of Community Health is an equal opportunity employer, services, and programs provider.

| FOR OFFICE USE ONLY | |
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| Eligibility Certification Signature | Date Prepared |
| Payment Approval Signature | Coverage Period<br>From:_____ To:_____ |
| NOTES: | |