Pennsylvania Health Fund Zero Co-Pay Program Application

Patient Information:

Name: _____ Phone: _____ Email: _____

Social Security #: _____ Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Eligibility Criteria:

☒ I have active health insurance that requires a co-pay from the patient at time of service.

☒ I receive medical services from the following PA Health Commission designated Certified Center of Excellence:

Olivero Pediatrics
Port Matilda, PA

☒ I meet ***one*** of the following criteria:

Choose one:

☐ Child	☐ Caretaker
Person under 18 years old or a young adult under 26 years old who is a dependent under a parent's health insurance policy.	A primary caretaker that resides in the same household of a person that receives zero co-pay benefits from PHF.

Olivero PEDIATRICS

Health Insurance Information:

☐ No Insurance ☐ Private/HMO insurance ☐ Medicaid

☐ Medicare: ☐ Part A ☐ Part B ☐ Part D ☐ Medicare Advantage

☐ Other: _____

Primary Insurance:

Plan Name: _____ Phone: _____ Fax: _____

ID/Policy #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____

Relationship to Patient: _____

Olivero PEDIATRICS

Patient Declaration

I promise:

- The information on this form is correct and complete.
- I will notify the Pennsylvania Health Fund (PHF) Zero Co-Pay Program within thirty (30) days if there is any change in the status of my eligibility to participate in this program.
- Not to attempt to claim or submit any costs associated with the assistance I receive under the Pennsylvania Health Fund Zero Co-Pay Program to any person or entity, including my Medicare Part D plan.
- Not to seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the financial support I receive under this program.

I authorize the following communications:

- Specifically, I authorize PHF to contact me to request my assistance with analysis related to the quality and efficacy of the PHF program.
- When signing this application, I am agreeing to allow PHF or its agent to contact me or my healthcare provider for additional information, if needed, related to my eligibility.

Patient Authorization To Share Health Information: I allow my doctor(s), any healthcare providers, and my health plan or insurers to give medical information related to my use or need of the PHF Zero Co-Pay Program: I understand:

- This information can include spoken or written facts about my health and payment benefits.
- It can include copies of my health records.
- People who work for PHF, the Program Administrator or agents of PHF may see my information but they may use it only to help me establish eligibility for the Zero Co-Pay Program and to run the Program.
- I authorize the PHF Program to contact my insurer, other potential funding sources, including the Centers for Medicare and Medicaid Services, social workers or patient advocacy organizations on my behalf in order to determine if I am eligible for health insurance coverage or other funds, and disclose to them information contained in my PHF Zero Co-Pay Program application.
- Every effort will be made to keep my information private but if it is accidentally given out, federal privacy laws will not protect it.
- PHF and the Program Administrators reserve the right without notice to change the application form, change the program or program criteria or stop assistance provided by the program at any time.

- At any time, I can revoke this consent by contacting PHF through any PA Health Commission designated Certified Center of Excellence, but it will not change any actions taken before I withdraw consent.
- I have a right to see or copy information given to PHF or the Program Administrators.
- This Authorization will last until I am no longer participating in the Program or sooner as limited by applicable state law.

I know that I may refuse to sign this form. My choice about whether to sign this form will not change the way healthcare providers or insurers treat me. If I refuse to sign this form, I know that this means that I may no longer be able to participate in the Zero Co-Pay Program.

_____	_____	_____
Patient or Parent/Guardian	Signature	Date

1243 Skytop Mountain Rd. • Suite 4 • Port Matilda, PA 16870-7725
Ph: (814) 499-3009 • Fax: (814) 470-4421
http://www.OliveroPediatrics.com