CONFIDENTIAL FAX

Please use 844-421-8008 for all faxes

❒ **ADAP Application**

❒ **OA-HIPP Application**

❒ **Medicare Part D Application**

ADAP Toll Free Phone: *844-421-7050*

 # Pages (Incl. cover page): _____

Date: _____

SENDER INFORMATION

Enrollment Worker Name: _____

Enrollment Site Name: _____

Enrollment Site Number: _____

Enrollment Worker E-mail: _____

Enrollment Worker Phone: _____

Enrollment Worker Secure Fax #: _____

CLIENT INFORMATION

First Name: _____ Last Name: _____

Client ID: _____ Date of Birth: _____

At this time, please submit documentation (ADAP Consent Form and/or ADAP paper applicaiton) ***only*** for new applicants, clients with expired eligibility and clients with a change in health coverage status or mailing address. Please check the appropriate checkbox(es) to indicate what is being submitted:

❒ New Client Application

❒ Existing Client Application

❒ Supporting Documentation

❒ Health Coverage Status Change

❒ Mailing Address Change

For a client with expired eligibility:

❒ Re-enrollment

❒ SVF with changes

❒ SVF with no changes

❒ Client is or will be out of medications in ____ days.

Comments:

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