



STOP and take 5 minutes to complete & return this form to SPBP to make sure that your health benefits stay active. DO NOT RISK LOSING YOUR BENEFITS.

COMMONWEALTH OF PENNSYLVANIA
 DEPARTMENT OF PUBLIC WELFARE
 P.O. BOX 8808
 HARRISBURG, PA 17105-8808

**SPECIAL PHARMACEUTICAL BENEFITS PROGRAM (SPBP)
 RECERTIFICATION FORM**

Strike out any information that is incorrect & print the correct information in a blank area in Section A. If you are reporting a change to your name, address, or date of birth, you will need to provide proof.

A	NAME and ADDRESS	SPBP ID NUMBER
		DATE of BIRTH
		TELEPHONE or MOBILE (CELL) NUMBER ()
		LANGUAGE PREFERENCE: English Spanish Other

B	FAMILY COMPOSITION (INCLUDES SPOUSE AND CHILDREN UNDER AGE 21 WHO LIVE WITH YOU)				
	NAME (Last, First, Middle Initial)	BIRTH DATE	SEX M F	SOCIAL SECURITY NUMBER	RELATIONSHIP TO YOU

ATTACH EXTRA SHEET OF PAPER IF NEEDED FOR SECTIONS A B & C

C	<p>PROVIDE YOUR INCOME INFORMATION: YOUR TOTAL ANNUAL GROSS INCOME _____</p> <p>LIST THE SOURCE(S) AND GROSS AMOUNT(S) OF INCOME RECEIVED AND HOW FREQUENTLY PAID:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">SOURCE _____</td> <td style="width: 16.5%;">WEEKLY _____</td> <td style="width: 16.5%;">BI-WEEKLY _____</td> <td style="width: 34%;">MONTHLY _____</td> </tr> <tr> <td>SOURCE _____</td> <td>WEEKLY _____</td> <td>BI-WEEKLY _____</td> <td>MONTHLY _____</td> </tr> <tr> <td>SOURCE _____</td> <td>WEEKLY _____</td> <td>BI-WEEKLY _____</td> <td>MONTHLY _____</td> </tr> </table> <p>LIST THE SOURCE(S), GROSS AMOUNT(S) OF INCOME RECEIVED AND HOW FREQUENTLY PAID FOR EACH FAMILY MEMBER LISTED ABOVE IN SECTION B (INCLUDE SPOUSE, HOUSEHOLD MEMBERS AND CHILDREN UNDER AGE 21 WHO LIVE WITH YOU)</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">NAME OF FAMILY MEMBER _____</td> <td style="width: 16.5%;">WEEKLY _____</td> <td style="width: 16.5%;">BI-WEEKLY _____</td> <td style="width: 34%;">MONTHLY _____</td> </tr> <tr> <td>SOURCE _____</td> <td>WEEKLY _____</td> <td>BI-WEEKLY _____</td> <td>MONTHLY _____</td> </tr> <tr> <td>SOURCE _____</td> <td>WEEKLY _____</td> <td>BI-WEEKLY _____</td> <td>MONTHLY _____</td> </tr> <tr> <td>SOURCE _____</td> <td>WEEKLY _____</td> <td>BI-WEEKLY _____</td> <td>MONTHLY _____</td> </tr> </table> <p>IF BY THE INFORMATION YOU HAVE PROVIDED IT APPEARS YOU MIGHT BE ELIGIBLE FOR MEDICAL ASSISTANCE, YOU MAY BE CONTACTED TO APPLY FOR MA BENEFITS. IF YOU HAVE PREVIOUSLY/RECENTLY APPLIED PLEASE INDICATE BELOW.</p> <p>I HAVE PREVIOUSLY/RECENTLY APPLIED FOR MA BENEFITS: YES _____ NO _____</p> <p>DATE OF DENIAL: _____ I AM CURRENTLY RECEIVING THE FOLLOWING BENEFITS:</p> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">BENEFIT AWARDED: _____</td> <td style="width: 40%;">DATE: _____</td> </tr> <tr> <td>BENEFIT AWARDED: _____</td> <td>DATE: _____</td> </tr> </table>				SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	NAME OF FAMILY MEMBER _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	SOURCE _____	WEEKLY _____	BI-WEEKLY _____	MONTHLY _____	BENEFIT AWARDED: _____	DATE: _____	BENEFIT AWARDED: _____	DATE: _____
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BENEFIT AWARDED: _____	DATE: _____																																			
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HEALTH COVERAGE INFORMATION

D Place a checkmark (✓) in the box to indicate all health programs or Private Insurance in which you are enrolled. Provide a copy of the front and back of all your Membership ID Cards.

DO NOT INCLUDE THE SPBP PROGRAM.

I HAVE NO MEDICAL INSURANCE, PRESCRIPTION OR OTHER HEALTH COVERAGE – GO TO SECTION E

<input checked="" type="checkbox"/> NAME OF PROGRAM		
<input type="checkbox"/> Medicare Part A	<input type="checkbox"/> Medicare Part B	<input type="checkbox"/> Medicare Part D Prescription
<input type="checkbox"/> Medicare Advantage Plan (HMO)	<input type="checkbox"/> PA Department of Public Welfare Medical Assistance Program	<input type="checkbox"/> United States Veteran's Administration
<input type="checkbox"/> NAME OF OTHER PRIVATE INSURANCE NOT INCLUDED ABOVE:		
REMEMBER TO PROVIDE COPIES OF <u>ALL</u> INSURANCE ID CARDS FRONT AND BACK		

E CERTIFICATION STATEMENT (MUST BE SIGNED AND DATED BY THE CLIENT, LEGAL GUARDIAN, OR AUTHORIZED REPRESENTATIVE) I HEREBY CERTIFY THAT ALL THE ABOVE INFORMATION IS TRUE AND CORRECT AND THAT I AM A PENNSYLVANIA RESIDENT.

SIGNATURE OF SPBP CLIENT (LEGAL GUARDIAN IF THE SPBP CLIENT IS A MINOR, OR CLIENT'S AUTHORIZED REPRESENTATIVE)

DATE

RELATIONSHIP OF AUTHORIZED REPRESENTATIVE _____

CLIENTS MUST ADVISE SPBP STAFF OF ANY CHANGES IN ADDRESS, FAMILY COMPOSITION, INCOME AND/OR INSURANCE COVERAGE.

ALL INFORMATION SUBMITTED IS CONFIDENTIAL AND WILL ONLY BE USED FOR THE PURPOSES OF THE SPECIAL PHARMACEUTICAL BENEFITS PROGRAM.

IF YOU NEED HELP COMPLETING THIS RECERTIFICATION FORM PLEASE CALL:

1-800-225-7223

RETURN THE COMPLETED RECERTIFICATION FORM AND THE COPIES OF DOCUMENTATION TO:

**DEPARTMENT OF PUBLIC WELFARE
SPECIAL PHARMACEUTICAL BENEFITS PROGRAM (SPBP)
P.O. BOX 8808
HARRISBURG, PENNSYLVANIA 17105-8808**

OR FAX TO: 1-717-651-3608