Hepatitis C Pre-Treatment Insurance Screen

MRN_____

DOB_____

Name_____ Phone Number_____

1. Do you currently have:

a. Private Health Insurance for yourself or through your spouse?

No ___ Yes ___ **[If yes, get copy of insurance card]**

b. Medicaid?

No ___ Yes ___

c. Medicare- Part D?

No ___ Yes ___

d. Denali Kid Care?

No ___ Yes ___

e. VA Benefits

No ___ Yes ___, currently eligible & registered for benefits? Yes/No

f. TriCare?

No ___ Yes ___

Screening done by: _____

Date: _____ / _____ / _____

Next step:

□ Contract consent

□ Support Path

□ Prior authorization process