Hepatitis C Pre-Treatment Insurance Screen

DOB_____ MRN_____

Name_____ Phone Number_____

Do you currently have:

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

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

2. Medicaid **-OR-** Denali Kid Care? (circle which one)

   No ___ Yes ___

3. Medicare

   a. Medicare Part A/B only? No ___ Yes ___

   b. Medicare Part D? No ___ Yes ___

   c. Medicare with Medicaid? No ___ Yes ___

   [If Medicaid & Medicare without Part D, submit through Medicare pharmacy program]

4. VA Benefits

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

5. TriCare?

   No ___ Yes ___

Screening done by: _____ Date: _____ / _____ / _____

Next Steps:

For “yes” to 1, 2, 3b, 3c: begin prior authorization process.

For “yes” to 3a or “no” to everything: begin patient assistance program process.
See Treatment Reference Tools>Patient Assistance Programs

For VA/TriCare, coordinate with local VA for coverage and treatment.