This website is used to support online enrollment for PA Dept of Health, Special Pharmaceutical Benefits Program.

MRxEnroll

pennsylvania
DEPARTMENT OF HEALTH

Home Services

Start your enrollment by clicking the button below.

Begin Enrollment

I Have an Account

Email Address

Password

Log In

Need help signing in?

MagellanRx MANAGEMENT

©2015-2018 Magellan Health, Inc.

Demographic Information

Please enter the following information to begin the enrollment process.

State *

Pennsylvania

First Name *

First Name

Last Name *

Last Name

Email *

Email

Email - Re-enter your email address to confirm *

Re-enter your email address to confirm

Are you Re-Enrolling? *

○Yes ○No

Submit Cancel

©2015-2018 Magellan Health, Inc.

1 Applicant & Family — 2 Other Health Coverage — 3 Household Information — 4 HIV Confirmation — 5 Authorizations — 6 Review & Submit

Applicant & Family

Last Name *
Hoffman

First Name *
Sean

Middle Initial
Middle Initial

Suffix (Sr., Jr., etc.)
Suffix (Sr., Jr., etc.)

Date of Birth *
MM/DD/YYYY

SPBP ID number (if known)
SPBP ID number (if known)

Social Security Number *
999-99-9999

Copy of Social Security card

☐ I do not have a Social Security Number

Home Phone
(555)555-5555

Cell Phone
(555)555-5555

☑ Opt-in to receive text updates.

Sex at Birth
Select

Current Gender *
Select

Ethnicity
Select

Race
Select

Preferred Language *
Select

red (*) asterisk denotes a required field

Home Address *
Include proof of residency with your application

Proof of residency

City *
City

State *
Select...

Zip Code *
Zip Code

Preferred Mailing Address
Include proof of residency with your application

City
City

State
Select...

Zip Code
Zip Code

Has your CD4 count ever dropped below 200 cells/µl?

○ Yes
○ No
○ Not Sure

Save As Draft | Next

MagellanRx MANAGEMENT

©2015-2018 Magellan Health, Inc.
All Rights Reserved.

MRxEnroll

pennsylvania DEPARTMENT OF HEALTH

Home Services

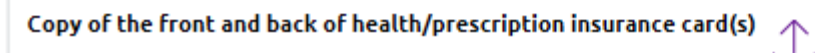
Other Health Coverage

Do you currently have any other health care coverage? *

- (•) Yes (Complete the insured section below and provide a copy of your insurance card with your application.)
- ( ) No (Complete the uninsured section below.)

Insured Section

Check each type of coverage that you currently have:

- [ ] Medicare Part A
- [ ] Medicare Part B
- [ ] Medicare Part C/Advantage Plan (HMO)
- [ ] Medicare Part D
- [ ] Medicaid/Medical Assistance
- [ ] U.S. Veterans Administration
- [ ] Other 
- [ ] Private Insurance

Copy of the front and back of health/prescription insurance card(s)

If you have insurance, does it cover prescription medications? *

( ) Yes ( ) No

red (*) asterisk denotes a required field

Previous | Save As Draft | Next

Privacy Policy / Terms of Use / Disclaimer / Nondiscrimination

MagellanRx MANAGEMENT

©2015-2018 Magellan Health, Inc. All Rights Reserved.

Other Health Coverage

Do you currently have any other health care coverage? *

- ○ Yes (Complete the insured section below and provide a copy of your insurance card with your application.)
- ◉ No (Complete the uninsured section below.)

Uninsured Section

If you do not have insurance, please check the reason why. *

- ○ Non Citizen
- ○ Cannot afford the cost/premiums
- ○ I decided not to apply for other health coverage
- ○ Other [Other Reason]

Have you applied for Medicaid in the last 12 months?

○ Yes ○ No

red (*) asterisk denotes a required field

Previous | Save As Draft | Next

©2015-2018 Magellan Health, Inc. All Rights Reserved.

Household Information

Provide information for all family members who live in your household. Family members include your spouse and your children under 21 who reside in the same household; if you are under 21, include your parents if you reside in the same household.
(Note: If you are a single/unmarried applicant 21 or older without dependents, do not list any family members.)

Add Another Family Member

	Type of Income	Income Received		
		Self	Spouse	Family Members
1	Salary/wages/bonus/commissions (before deductions)	☐	☐	☐
2	Unemployment compensation or veterans benefits	☐	☐	☐
3	Social Security retirement/survivor's benefits/SSI	☐	☐	☐
4	Other pensions or retirement	☐	☐	☐
5	Social Security disability or other disability income	☐	☐	☐
6	Worker's compensation or sick benefits	☐	☐	☐
7	Alimony or child support	☐	☐	☐
8	Dividends/interest/royalties/capital gains	☐	☐	☐
9	Rental income (gross income minus expenses)	☐	☐	☐
10	Public assistance (Do not include food stamps or LIHEAP)	☐	☐	☐
11	Business/self-employed/partnerships	☐	☐	☐

Proof of household income

Click here for examples of acceptable proof of income.

If you have a case manager, complete this section.

Name of Case Manager	Case Manager Phone Number	Case Manager Email
Name of Case Manager	Case Manager Phone Number	Case Manager Email

Name of Agency	Address of Agency
Name of Agency	Address of Agency

If there are any items with an asterisk (*) - they are required.

Previous | Save As Draft | Next

©2015-2018 Magellan Health, Inc.
All Rights Reserved.

MRxEnroll

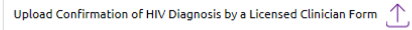
pennsylvania
DEPARTMENT OF HEALTH

Home Services

HIV Confirmation

Confirmation of HIV Diagnosis by a Licensed Clinician

If this is your first time applying to SPBP, email or print the below Confirmation pdf so your licensed clinician can complete it. Your clinician must include his/her printed name, NPI number, signature and date. This section does not need to be completed for applicants re-enrolling in SPBP. Then upload the Confirmation pdf to this section.



Upload Confirmation of HIV Diagnosis by a Licensed Clinician Form

If there are any items with an asterisk (*) - they are required.

Previous   Save As Draft   Next

MagellanRx MANAGEMENT

©2015-2018 Magellan Health, Inc.
All Rights Reserved.

8	Confirmation of HIV Diagnosis by a Licensed Clinician

1. If this is your first time applying to SPBP, give this section to your licensed clinician to complete. Your clinician must include his/her printed name, NPI number, signature, and date below.
2. This section does not need to be completed for applicants re-enrolling in SPBP.

Applicant's name (printed) ______________________ SPBP ID number (if applicable) ______________

Date of patient's last appointment ______________________

Based on my personal knowledge and evidence from the medical record, by providing my signature below I certify that appropriate laboratory tests conclude the patient named in the application has a diagnosis of HIV. I understand that payments for specific HIV medications will be sought from state and federal funds under the Special Pharmaceutical Benefits Program. The misrepresentation, concealment, or falsification of information concerning the diagnosis of the applicant may subject the provider to civil or criminal sanctions.

Prescribing clinician's name (printed) ______________________ NPI number ______________

Prescribing clinician's signature ______________________ Date ______________

Return the completed form to:
Department of Health
Special Pharmaceutical Benefits
Program
P.O. Box 8808
Harrisburg, PA 17105-8808
Or email to:
SPBP@magellanhealth.com
Or fax to: 888-656-0372

pennsylvania
DEPARTMENT OF HEALTH
Special Pharmaceutical Benefits Program

MRxEnroll

Home Services

Authorization for Disclosure of HIV-Related Information to Specified Persons

Please read and digitally attest.

SPBP will not communicate with anyone other than you or your health care professional (i.e., clinician or case manager) regarding your information, unless this document is completed.

List all individuals below that you grant consent for SPBP to communicate with.

1. I **Sean Hoffman** am applying or re-applying for benefits from the Special Pharmaceutical Benefits Program (SPBP) of the Department of Health.
2. I understand that SPBP may need information about me or may have to discuss my circumstances with me or other persons in order to determine whether or not I am eligible for benefits and to resolve issues regarding my participation in SPBP.
3. I understand that my information is or may be confidential information under the Confidentiality of HIV-Related Information Act.
4. I understand that in order for SPBP to have discussions about my circumstances or to exchange information about me with persons other than me or my health care provider and case manager, I will need to give SPBP and its staff permission to talk to those persons.
5. I understand that signing this document will provide that permission for six months, unless I tell SPBP I do not want them to continue talking with a specific person or unless I say that a specific event will cause me to withdraw my permission.
6. I understand I will need to sign a new authorization each time I reapply for the program.
7. I understand that SPBP will not discuss my circumstances with persons other than me or my health care provider and case manager without my permission and that this could impact my ability to apply for the program.

I **Sean Hoffman** authorize the Special Pharmaceutical Benefits Program of the Pennsylvania Department of Health and its affiliates (Department of Aging and Magellan Health) to disclose information related to my HIV status and my proposed or ongoing participation in the Special Pharmaceutical Benefits Program for the purpose of enrolling, re-enrolling, or obtaining benefits that are or may be due to me under that program to any of the following persons.

This authorization may be withdrawn at any time before the actual disclosure takes place. **This authorization will expire six months from the date of my enrollment** or when I am no longer participating in the program, if I have not withdrawn it earlier. I have read or someone has read and explained this authorization to me.

+Add Individual or Agency

☐ I have read or someone has read and explained this authorization to me *

☐ I am the legal guardian

If there are any items with an asterisk (*) - they are required.

Previous | Save As Draft | Next

MagellanRx MANAGEMENT.

©2015-2018 Magellan Health, Inc.
All Rights Reserved.

1 Applicant & Family | 2 Other Health Coverage | 3 Household Information | 4 HIV Confirmation | 5 Authorizations | 6 Review & Submit

Authorization for Disclosure of HIV-Related Information to Specified Persons

Please read and digitally attest.

SPBP will not communicate with anyone other than you or your health care professional (i.e., clinician or case manager) regarding your information, unless this document is completed.

List all individuals below that you grant consent for SPBP to communicate with.

1. I **Sean Hoffman** am applying or re-applying for benefits from the Special Pharmaceutical Benefits Program (SPBP) of the Department of Health.

2. I understand that SPBP may need information about me or may have to discuss my circumstances with me or other persons in order to determine whether or not I am eligible for benefits and to resolve issues regarding my participation in SPBP.

3. I understand that my information is or may be confidential information under the Confidentiality of HIV-Related Information Act.

4. I understand that in order for SPBP to have discussions about my circumstances or to exchange information about me with persons other than me or my health care provider and case manager, I will need to give SPBP and its staff permission to talk to those persons.

5. I understand that signing this document will provide that permission for six months, unless I tell SPBP I do not want them to continue talking with a specific person or unless I say that a specific event will cause me to withdraw my permission.

6. I understand I will need to sign a new authorization each time I reapply for the program.

7. I understand that SPBP will not discuss my circumstances with persons other than me or my health care provider and case manager without my permission and that this could impact my ability to apply for the program.

I **Sean Hoffman** authorize the Special Pharmaceutical Benefits Program of the Pennsylvania Department of Health and its affiliates (Department of Aging and Magellan Health) to disclose information related to my HIV status and my proposed or ongoing participation in the Special Pharmaceutical Benefits Program for the purpose of enrolling, re-enrolling, or obtaining benefits that are or may be due to me under that program to any of the following persons.

This authorization may be withdrawn at any time before the actual disclosure takes place. **This authorization will expire six months from the date of my enrollment** or when I am no longer participating in the program, if I have not withdrawn it earlier. I have read or someone has read and explained this authorization to me.

Full name and title or name of organization, agency, etc. 1 - Remove Agency

Full name and title or name of organization, agency, etc.

Address

Address

Phone Number

Phone Number

Email

Email

+Add Individual or Agency

☐ I have read or someone has read and explained this authorization to me *

☐ I am the legal guardian

If there are any items with an asterisk (*) - they are required.

Previous | Save As Draft | Next

©2015-2018 Magellan Health, Inc. All Rights Reserved.

1 Applicant & Family
2 Other Health Coverage
3 Household Information
4 HIV Confirmation
5 Authorizations
6 Review & Submit

Review

- Applicant & Family
- Other Health Coverage
- Household Information
- HIV Confirmation
- Authorizations
- Registration

Previous | Save As Draft | Submit

1 Applicant & Family | 2 Other Health Coverage | 3 Household Information | 4 HIV Confirmation | 5 Authorizations | 6 Review & Submit

Review

Applicant & Family - 8 items need attention

Other Health Coverage - 1 items need attention

Household Information

HIV Confirmation

Authorizations - 1 items need attention

Registration - 1 items need attention

Please enter a password to create an account so you can retrieve and continue your enrollment at a later time.

Email *

sean@hoffman.com

Password *

Password

Required

Confirm Password *

Confirm Password

Required

Cell Phone Number

999-999-9999

This will be used for Account Recovery

Previous | Save As Draft | Submit