

### About My Policy

In addition to keeping good records, you should be prepared to know some basic information about your health insurance and pharmacy coverage. Complete the following form so

you have this information on hand. Knowing these details about your policy and deductibles can make it easier to find answers to your questions.

#### Health Insurance

Insurance Company Name \_\_\_\_\_

Phone Number \_\_\_\_\_

Insurance Company Case Manager \_\_\_\_\_

Plan Name \_\_\_\_\_

Plan's Enrollment Period Dates \_\_\_\_\_

Type of Plan:

- HMO                       Medicare  
 POS                         Medicaid  
 PPO                        Other: \_\_\_\_\_

Group Number \_\_\_\_\_

ID Number \_\_\_\_\_

Co-pay, if any:

Office Visit \_\_\_\_\_ Specialist \_\_\_\_\_ Emergency Room \_\_\_\_\_

#### Specialty Pharmacy

Pharmacy Provider Name \_\_\_\_\_

Pharmacy Provider Phone Number \_\_\_\_\_

Factor Co-pay (per shipment, per month, etc.), if any \_\_\_\_\_

Factor Co-Insurance (per shipment, per month, etc.), if any \_\_\_\_\_

Annual Pharmacy or Factor Limit, if any \_\_\_\_\_

#### Annual Deductibles

Medical \_\_\_\_\_

Pharmacy \_\_\_\_\_

Lifetime Medical Cap, if any \_\_\_\_\_

Total Out-of-Pocket Cost Limit, if any \_\_\_\_\_

#### Healthcare Provider Contact Information

Type	Name	Address	Phone Number
Hemophilia Treatment Center (HTC)			
Physician			
Nurse			
Social Worker			