

DIAGNOSIS FORM INSURANCE ASSISTANCE SECTION

This form must be completed and signed by a Medical Doctor (M.D. or D.O.), Physician Assistant, or Nurse Practitioner who is licensed to practice.

I. Patient Information	
Applicant's Name (First, MI, Last)	Date of Birth (mm/dd/yyyy)

Does this patient have HIV infection? Yes No

II. Physician Information		
Physician Name:		
Address (Number, Street, Suite #)	City	Zip Code
Telephone Number	Fax Number	

Please note that the information on this form is being collected to determine eligibility for benefits under the Ryan White HIV/AIDS Treatment Extension Act of 2009 (Public Law 111-87) and is required by the California Department of Public Health (CDPH), Office of AIDS. The information may be used to determine eligibility for insurance assistance. Failure to provide the mandatory information may result in the application not being processed. You have the right to review the information maintained by CDPH unless access is exempt by law. To access the information, contact CDPH Insurance Assistance Section, MS 7704, P.O. Box 997426, Sacramento, CA 95899-7426, or by phone at (800) 367-2437.

I certify that the information provided on this form is true and correct to the best of my knowledge.

Licensed Health Care Provider Name (Printed)	License Number
Licensed Health Care Provider (Signature)	Date Signed