DEPARTMENT OF HEALTH SERVICES
Division of Public Health
F-44614B (Rev. 01/2015)

STATE OF WISCONSIN
AIDS/HIV Program
1-800-991-5532

AIDS/HIV DRUG INSURANCE PREMIUM SUBSIDY PROGRAM AND DRUG ASSISTANCE PROGRAM APPLICATION/RECERTIFICATION PART B – PHYSICIAN PORTION

The AIDS/HIV Program will maintain all information on this form confidential.

APPLICANT INFORMATION

Last Name	First Name	Middle Initial	Date of Birth

Street Address

City	State	Zip Code

HIV STATUS

Has this patient been diagnosed with HIV infection? ☐ Yes ☐ No

PRESCRIPTION INFORMATION

Is this patient currently prescribed antiretroviral medication? ☐ Yes ☐ No

If no, will this patient be prescribed antiretroviral medication in the next 90 days? ☐ Yes ☐ No

If not, please explain:

PHYSICIAN INFORMATION

Name (Print or type)	Telephone Number

Street Address

City	State	Zip Code

SIGNATURE – Physician	Date Signed

Return completed Part B of the Application/Recertification in an envelope marked **"CONFIDENTIAL"** to:

Division of Public Health
ATTN: ADAP
PO Box 2659
Madison, WI 53701-2659

Or fax to (608) 266-1288