WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 1090
Great Bend, KS 67530
1-800-877-5187
Fax # 620-793-1199

Tray
Enrollee Name
Address 1,
Address 2
City, State zip
Bar code

IMPORTANT

This form must be SIGNED and RETURNED by

DUE DATE: DECEMBER 15, 2016

WSHIP ELIGIBILITY VERIFICATION FORM (Basic and Basic Plus Plans) WSHIP must confirm that you continue to meet eligibility requirements. Your prompt response is appreciated. **Failure to respond may lead to termination of your coverage**. If you have questions, please call WSHIP at 1-800-877-5187.

WASHINGTON STATE RESIDENCY

1. ***Please provide your physical address and information below***.

Physical Address of your current residence - Required		Mailing Address **if different** than physical address		Billing Address **of 3rd party paying premiums (if applicable)**	
Name		Name		Name	
Address		Address		Address	
City		City		City	
State & Zip		State & Zip		State & Zip	

COUNTY OF RESIDENCE:

Telephone Number: ( )

Cell Number: ( )

Email Address:

(Optional) **Secondary Contact:** **Contact's Telephone Number:** ( )

Secondary contact is a person who will know how to get in touch with you if we are unable to reach you. We are not authorized to discuss your protected health information with a secondary contact unless appropriate documentation has been submitted.

OTHER COVERAGE INFORMATION

2. ***Please indicate your Medicare coverage below:***

   Medicare: Part A ❑ Part B ❑ Part D ❑ Not Eligible for Medicare* ❑

   * If you are 65 or older but not eligible for Medicare, please enclose proof of ineligibility.

3. ***Are you currently enrolled in a Medicare Prescription Drug Plan (PDP)?*** Yes ❑ No ❑

   If yes, please enclose a copy of your PDP card and indicate name and effective date below:

   Name of Medicare PDP _____ Effective Date_____

4. ***Are you enrolled in any other coverage such as Medicaid or a group health plan?*** Yes ❑ No ❑

   Name of other insurer _____ Effective Date_____

If you have other coverage and will CANCEL YOUR WSHIP POLICY, what is the effective date for cancellation?

_____

PLEASE SIGN BELOW: I attest that my responses on this form are true and complete.

X_____ _____/_____/_____

Signature **Date Signed**

Printed Name: _____ **Enrollee ID # <<participant>>**

SIGNATURE REQUIRED - *Stamped addressed envelope enclosed*