



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, 2021

WSHIP ELIGIBILITY VERIFICATION FORM (Non-Medicare 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: Please provide your physical address and information below.

Table with 3 columns: Physical Address of your current residence - Required, Mailing Address if different than physical address, Billing Address of 3rd party paying premiums (if applicable). Includes fields for Name, Address, City, State & Zip, Telephone Number, Cell Number, Email Address, and Secondary Contact information.

ARE YOU ELIGIBLE FOR MEDICARE? Yes [] No [] If you do not know or are unsure please call: 1-800-633-4227; or visit www.cms.gov/Medicare/Medicare.html; or go to your local Social Security office.

ARE YOU ELIGIBLE FOR MEDICAID? (Washington Apple Health)? Yes [] No [] Note: This includes expanded Medicaid that was implemented in 2014 as part of the Affordable Care Act. If you don't know or are unsure please call: 1-800-562-3022 or visit www.hca.wa.gov.

DO YOU HAVE COVERAGE OTHER THAN WSHIP? Yes [] No [] If Yes, in order to coordinate benefits, please provide the following: 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
Printed Name: _____

_____/_____/_____
Date Signed
Enrollee ID # <<participant>>

SIGNATURE REQUIRED

For your convenience we have enclosed a stamped addressed envelope.