WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

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

Enrollee Name _____

Address _____

City, State zip _____

IMPORTANT

This form must be SIGNED and RETURNED by

DUE DATE: DECEMBER 15, 2017

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***.

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:

Important! The premium you pay is based in part on the county you live in.

Telephone Number: ( )	**Email Address:**
Cell Number: ( )	

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

Secondary contact is a person who will know how to contact if we are unable to do so. We are not authorized to discuss your protected health information with a secondary contact unless you submit appropriate documentation.

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.*

If you have End Stage Renal Disease OR you are 65 or older but not eligible for Medicare, enclose proof of ineligibility.

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 **Date Signed**

Printed Name: _____ **Enrollee ID #** _____

SIGNATURE REQUIRED