WSHIP
WASHINGTON STATE HEALTH INSURANCE POOL

PO Box 780548
San Antonio, TX 78278
1-888-277-9135

IMPORTANT
This form must be SIGNED and RETURNED by
DUE DATE: DECEMBER 15, 2024

WSHIP ELIGIBILITY VERIFICATION FORM (Medicare-Eligible 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 1-888-277-9135.

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**		**Name & 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: ( )		**Email Address:**			
Cell Number: ( )					
(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 #** _____

SIGNATURE REQUIRED