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 (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** | | **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:**
**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.*

**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**