HEALTH INSURANCE VERIFICATION FORM

I hereby consent to allow my employer, former employer or insurance carrier named below, and the Wyoming Department of Health and/or its authorized agents or contractors, to share information regarding my insurance coverage, premiums, deductibles, and co-payments for the purpose of determining cost-effectiveness for the WHIPP program. This consent expires on termination of Medicaid eligibility.

Applicant Name	Client Number	SSN	Signature	Date

Address	City	State	Zip	Phone Number

HEALTH INSURANCE INFORMATION

Name/Address of Carrier

Is the policy employment related? Yes No

Is the policy individually (personally) purchased? Yes No

If yes, name of employer and address

Policy Holder

Policy Number

Group Number

Group Name

What is the charge to cover the subscriber/employee for premiums?

$_____ single plan $_____ family plan

weekly biweekly monthly semimonthly other _____

Can the employer and/or insurance company accept payment from the Division of Healthcare Financing (Medicaid) for premiums in lieu of a payroll deduction or private payment from the policy holder?

Yes No

If YES, enter employer/insurance federal tax ID# and address where premium payments should be mailed:

Tax ID: _____

Address: _____

_____

_____

If employment related, is there a waiting period before they can enroll in the health plan?

Yes No

If YES, date employee is eligible to enroll and the reason why there would be a delay in coverage?

If the policy is employment related, state the date that the payroll deduction will begin: _____

Deductible:_____ per: _____ Coinsurance/Co-pay:_____

Other: _____

Pregnancy Deductible (if applicable): _____

Coverage (mark all that apply)

Hospital	Physician	Surgical	Major Medical	Accident
Indemnity	Dental	Vision	Pharmacy	Supplement
Auto	Disease	Nursing Home	Pregnancy	HMO

Persons covered by policy:

Name	SSN	D.O.B.	Client ID

Comments:

Authorized Signature	Printed Name	Phone Number	Date

DHCF-WHIPP

Wyoming Medicaid
Health Insurance Premium Payment
Medical History Questionnaire

1. How many prescriptions are filled each month for the Medicaid client(s) in your household who are covered under this insurance policy? _____Average monthly cost $ _____
2. Are any of the Medicaid clients covered under this policy periodically institutionalized or currently living in an institution (mental institution, nursing home, or hospital, etc.)? Yes ____ No ____
3. Check all following conditions that apply to any Medicaid clients covered under this policy. List the name of the person with each condition and how often medical care is needed to treat the condition.

Condition	Yes	If yes, name of person with condition	How often is medical care required?
Diabetes			
Blood Disorder			
Cancer (please specify type)			
Mental Illness/Retardation			
Pregnancy			Due Date?
Heart Condition			
Asthma/Respiratory Ailment			
Scoliosis/Back Injury			
Stroke/Head Injury			
Organ transplant (explain)			
Seizure Disorder			
HIV Positive / Acquired Immune Deficiency (AIDS)			
Alcoholism / Drug Addiction			
List other Disease Condition			

4. Are any of the conditions checked "Yes" above excluded from coverage under this health insurance plan as a pre-existing medical condition? Yes _____ No _____
   If yes, list conditions not covered and when they will begin to be covered (if applicable)

_____
_____
_____
_____