HEALTH INSURANCE VERIFICATION FORM

HCF- WHIPP

Applicant Name:		ID Number:
SSN:	DOB:	Phone Number:
Address:	City:	State:

HEALTH INSURANCE INFORMATION

Policyholder's name:	Policyholder's DOB:
Policyholder's SSN:	Policy Number:
Group Name:	Group Number:
Name of Carrier:	
Address of Carrier:	

Type of policy coverage? ☐Individual ☐Individual + Children ☐Individual + Spouse ☐Family

What type of health insurance coverage do you have access to? ☐Employer ☐COBRA ☐Private

How are premiums paid? ☐Insured pays Carrier ☐Insured Pays Employer ☐Payroll Deduction

What is the premium for this policy? $_____

How often are the premiums paid? ☐Weekly ☐Bi-Weekly ☐Monthly ☐Semi-Monthly ☐Other

EMPLOYER INFORMATION

Name of Employer:	Employer Telephone:
Employer Mailing Address:	

Can the employer or insurance carrier accept payment from the Division of Healthcare Financing (Medicaid) instead of a payroll deduction or private payment from the policyholder? ☐ Yes ☐ No

If yes, enter employer or insurance carrier federal tax ID# and contact name and number for payments. Tax ID: _____ Contact Name:_____ Contact Number:_____

Please list the open enrollment dates for health insurance obtained through an employer?

Start Date ___/___/____ End Date ___/___/____

POLICY COVERAGE INFORMATION

List everyone covered by your policy, including Medicaid recipients. (Use extra paper if necessary.)

Name	Medicaid ID #	SSN	DOB	Medical Condition*	Pregnant?	Relationship to policyholder

*Submitting "Medical Condition" is optional, although, listing this information may benefit the applicant.

Deductible $_____ per _____ Coinsurance/Co-pay $_____ Pregnancy Deductible $_____

Coverage (Mark all that apply)

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

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

Authorized Signature:	Date:

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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 $_____

Are any of the Medicaid recipients covered under this policy periodically institutionalized or currently living in an institution (mental institution, nursing home, or hospital, etc.)? ☐ Yes ☐ No

Check all following conditions that apply to any Medicaid recipients 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 the person with the 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			

Send your completed Health Insurance Verification Form to:

HIPP Program
Wyoming Medicaid
Fiscal Agent
PO Box 667
Cheyenne, WY 82003
-OR-
Fax: 1-307-772-8405
-OR-
E**mail: WYThirdPartyLiability@Conduent.com**

If you have questions, please call us at 1-800-251-1269