

## 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:         | HR/Benefits Contact Name: |
| Employer Mailing Address: |                           |
| Employer Telephone:       | Employer Fax:             |

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 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?

**POLICY COVERAGE INFORMATION** Start Date \_\_\_\_/\_\_\_\_/\_\_\_\_ End Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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)

|                                    |                                    |                                  |  |                                       |
|------------------------------------|------------------------------------|----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Hospital  | <input type="checkbox"/> Physician | <input type="checkbox"/> Disease | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Nursing Home |
| <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Dental    | <input type="checkbox"/> Vision  | <input type="checkbox"/> Pharmacy      |                                       |

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 / Impairment                  |     |   |                                     |

Send your completed Health Insurance Verification Form to:

WHIPP Program  
Wyoming Medicaid  
225 East John Carpenter Freeway, Suite 500  
Irving, TX 75062

-OR-  
Fax: 1-214-313-1315

-OR-  
Email: [WHIPP@gainwelltechnologies.com](mailto:WHIPP@gainwelltechnologies.com)

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If you have questions, please call us at 1-844-512-2672