Kentucky Employees' Health Plan
Department of Employee Insurance
Enrollment Information Branch
kehp.ky.gov 1-888-581-8834

MEDICAID ELIGIBILITY/TERMINATION FORM

To be used to verify eligibility for coverage in the Kentucky Employees' Health Plan (KEHP)

To be filled out by KEHP Planholder or adult dependent over the age of 18

***If adult dependent opened their own Medicaid/KYNECT case, then they must fill out and sign this form**

Parent/Guardian/Adult Dependent who opened Medicaid/KCHIP/KYNECT case: _____ **SS#** _____

KEHP Member Name: _____ **SS#** _____

Name(s) of individual(s) gaining/losing coverage **SS#**

_____ _____

_____ _____

_____ _____

_____ _____

I hereby give permission for the Department for Medicaid Services to release information to

_____, **Insurance Coordinator/Human Resources Generalist and to the**

Department of Employee Insurance.

_____ _____
Parent/Guardian/Adult Dependent **Date** **IC/HRG** **Date**

_____ _____
Authorized Person at Department for Medicaid Services **Date** **IC/HRG Fax Number**

FOR OFFICIAL USE ONLY

Effective Date of Coverage: _____ **Termination Date of Coverage:** _____

Medicaid ❑ **KCHIP** ❑ **QHP** ❑ **QHP Effective Date:** _____

Reason for Termination of coverage:
- ❑ **Failure to recertify / provide verification timely**
- ❑ **Loss of Eligibility**
- ❑ **Voluntarily dropped coverage**
- ❑ **Non-payment of premium**

Please give date member was notified of eligibility or termination:

_____

Attention ICs/HRGs: Please fax this form with a cover sheet to 502-564-0039, Attn: Laura Graham in the Department for Medicaid Services. You should receive the completed form back within 72 hours. Please forward completed form and all QE documents to DEI Enrollment Information Branch (EIB). If you do not receive the form, or have questions or concerns, please contact EIB at 502-564-1205 or email EIB@ky.gov.