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: ________

KEHP Member Name: ________

Name(s) of individual(s) gaining/losing coverage ________

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.

Revised 04/15/2020