



## 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 Plan holder 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

\*\* Please Print in this Section

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 authorize the Division of Medicaid Services (DMS) to release information to

\_\_\_\_\_, Insurance Coordinator/Human Resource Generalist and to the  
 Kentucky Employees' Health Plan.

\*\*\*Please sign in the section below

Parent/Guardian/Adult Dependent \_\_\_\_\_ Date \_\_\_\_\_

IC/HRG \_\_\_\_\_ Date \_\_\_\_\_

Authorized Person at Div of Medicaid Serv. \_\_\_\_\_ 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
- Loss of Eligibility
- Voluntarily dropped coverage
- Non-payment of premium

Please give date member  
 was notified of eligibility or  
 termination. \_\_\_\_\_

Attn ICs/HRGs: Please fax this form with cover sheet to 502-564-0039, attn: Amanda Kelley in the Division of 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 Kimberly Dennis or Christina Winans in EIB at 502-564-1205.