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| **Client Demographic Data** ***(information provided must match the enrollment application)*** |
| Client Name: |  | Date of Birth: |  |
| Complete Address: |  |
| Social Security Number: |  | Primary Phone Number: |  |
| **Client Enrollment Data**  |
| Household Income:  |  | Family Size: |  | Did the Marketplace determine the client as Medicaid-eligible? [ ]  Yes [ ]  No (*if yes,* ***do not enroll*** *client in a Marketplace insurance plan)* |
| Complete the remaining questions in this section if client is enrolling in a Marketplace insurance plan. |
| *Please attach proof of income & Virginia residency and a copy of the insurance premium data from the Marketplace application.* |
| Check One:  | [ ]  New Enrollment |  [ ]  Re-enrollment |  [ ]  Corrected/Updated Enrollment Information  |
| Name of Insurance Carrier: |  | Plan Effective Date: |  |
| Name of Insurance Plan Enrolled In: |  |
| Monthly Premium Before Tax Credit Applied: |  | Tax Credit Amount: |  | Monthly Premium After Tax Credit Applied: |  |
| Maximum Out of Pocket(MOOP): |  | Member ID or Billing ID, if available: |  |
| Premium Effective Date *(if different from the Plan Effective Date):* |  |
| *\*Only enroll clients into family plans if all persons being enrolled are participants in the VDH medication access program.* |
| Did the client enroll in a family plan? |  [ ]  Yes [ ]  No |
| If yes, provide name of subscriber/main policy holder: |
| List the names of family members on the family plan & their dates of birth. |
| Name: |  | Date of Birth: |  |
| Name: |  | Date Of Birth: |  |
| Comments: |  |
| Enrollment Assiter Name: |  | Agency/Company: |  |
| Agency Phone Number: |  | Date Enrollment Completed: |  |
| **This Section for VDH Payment Processor Use Only**  |
| Payment Date: |  | Payment Amount: |  |
| Payment Method: |  | Auth#/Check #/Etc: |  |
| Date Keyed in Database: |  | Keyed By: |  |
| **This Section for VDH Staff Use Only** |
| Initial Rvw/Cmplt: |  | Date: |  | Data Entry: |  | Date: |  |
| Addtl Pmt Req – Amt: |  | Date Due: |  | Mths Addtl Pmt Cov: |  |
| Name of Insurance Carrier: |  | Insurance Member ID: |  |
| Plan End Date: |  | Verif Mthd: | [ ] Client/client bill | [ ] C.M./Provider | [ ] Carrier |
| Comments: |  |