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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: | |  | | | | | Household Size: | | | | | | |  | | | | | Is the client eligible for Medicaid?  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.*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **\*\*Please ensure information provided below is based on a new/updated Marketplace application\*\*** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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 name of family member on the family plan & his/her date of birth. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name: |  | | | | | | | | | | | | | | | | | | | Date of Birth: | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Comments: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Enrollment Assister Name: | | | | | | | |  | | | | | | | | | | | | | | | | | | | Agency/Company: | | | | | | | |  | | | | | | | | | | | |
| Assister 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: | |  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |