VDH VIRGINIA DEPARTMENT OF HEALTH
Protecting You and Your Environment

After completing the Marketplace application for a client, please fill in the appropriate fields below and send this form to the VDH.

Insurance Enrollment Worksheet

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:							

If the enrollment site is a VDH contracted service provider and you have an SFTP (secured) invoice folder, you may submit documents to the folder. For all others, please fax the documents to 804-864-8050.
If you need assistance, please call 1-855-362-0658;