Kentucky Employees' Health Plan
Enrollment Information Branch
Kehp.ky.gov 888-581-8834, Option 3

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 an 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: **SS#**

KEHP Member Name: **SS#**

Name(s) of individual(s) gaining/losing coverage: **SS#**

I hereby give permission for the Department for Medicaid Services to release information to, , Insurance Coordinator/Human Resource Generalist and to the Department of Employee Insurance.

Parent/Guardian/Adult Dependent **Date** **IC/HRG** **Date**

Authorized Person at Dept. for Medicaid Services **Date**

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: Email this form using encryption to dms.eligibility@ky.gov. If you are unable to email, fax with a cover sheet to 502-564-0039. 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, contact EIB at 502-564-1205 or by email eib@ky.gov.

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