Pennsylvania's Children's Health Insurance Program

We Cover All Kids.

Commonwealth of Pennsylvania

CHIPcoversPAkids.com

Application for Health Care Coverage

If you would like a copy of this application in Spanish, please call us at 1-800-986-KIDS (CHIP).

Si desea una copia de esta solicitud en Español llámenos al 1-800-986-KIDS (CHIP).

Important information about health care benefits. Please have someone read this to you.

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ណាម្នាក់ ឲ្យអានព័ត៌មាននេះជូនអ្នក ។

Важная информация относительно пособий на медицинское обслуживание. Пожалуйста, попросите кого-нибудь прочитать ее вам.

Thông tin quan trọng về quyền lợi chăm sóc sức khỏe. Xin nhờ người khác đọc thông tin này cho quý vị.

Information About Health Care Coverage

For assistance with completing your application, call us at 1-800-986-KIDS (CHIP).

What Programs are Available?

Children's Health Insurance Program (CHIP):

Free CHIP:
Provides free health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.

Low-Cost CHIP and *Full-Cost* CHIP:
Provides *low-cost* health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. Families must pay a monthly premium for each child and there are copayments for certain services.

Medical Assistance:

Provides free health insurance for children, teens, and adults who qualify.

Enrollment in CHIP and Medical Assistance is based on household size and income. This application will work for all of the above programs. All information you provide on this form is confidential and may be shared between the programs as necessary. The age of your child(ren) as well as your household income will determine which program is right for your family.

- If your child is not eligible for CHIP, this application will be sent to the County Assistance Office to see if either you or your child is eligible for Medical Assistance.

- You will get a letter from us within 30 days telling you what has happened to the application and what to expect.

CHIP Benefits

- Doctor office visits
- Prescription drugs
- Dental
- Eye care and eyeglasses
- Diagnostic tests
- Durable medical equipment
- Emergency care
- Hearing care
- Home health care
- Hospitalization
- Immunizations
- Laboratory tests/x-rays
- Mental health services/substance abuse
- Pregnancy

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How to Apply

❶ Read the application carefully and complete all information. PLEASE PRINT. An application that is not complete will slow down the process for enrollment in health care coverage, if the applicant is eligible.

❷ If you need help completing any part of this application, please contact us at 1-800-986-KIDS (CHIP).

❸ Attach copies of proof of all household gross income (before taxes and deductions) that reasonably represents your household's current income. If possible, all income documents should be dated within 60 days of the date you apply. Proof of household income is listed below:

- One pay stub from the last 60 days for each person working in the household. Send more pay stubs if pay changes regularly. If you do not get pay stubs, submit a signed and dated letter from the employer on company letterhead which states the hourly rate, number of hours (regular and overtime) worked per pay, frequency of pay and gross pay. Bonus and commission information should be provided, as well. The employer's phone number and address should be included, in case we have any questions.

- If a household member is self employed: include the most recent federal income tax return and all related tax schedules and forms or submit a year-to-date profit and loss statement showing the business name, time frame being reported, gross income received, only business related expenses by line item, and the net profit. Please sign and date.

- If a household member is a seasonal or temporary employee: indicate the number of months worked during the year and if Unemployment Compensation is received when not working.

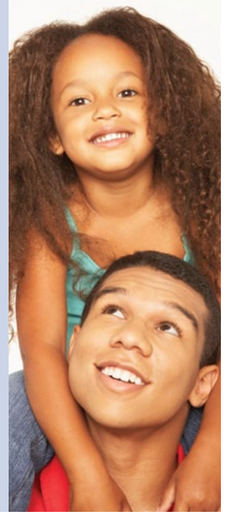
- If Unemployment Compensation is received by a household member: submit the Notice of Financial Determination award letter or check stubs.

- If Social Security, Survivor's or Disability benefits, retirement, pension, or Worker's Compensation is received: submit the most recent award letter, Form 1099, or bank statement which shows the direct deposits to the bank.

- If child support or alimony is received: submit the support order or a copy of the payment history for the past 12 months from the Department of Welfare's PA Child Support Enforcement System at www.childsupport.state.pa.us. If neither is available, a signed and dated letter from the parent paying support or ex-spouse paying alimony is acceptable. These letters should state the monthly amount being paid and identify the children or spouse for which it is being paid.

❹ If you are applying for someone who is not a U.S. Citizen, you must provide proof of their legal status by presenting documentation from the U.S. Citizenship and Immigration Service.

❺ When you have completed the application and gathered copies of all necessary supporting documentation, please sign and date the application and return it to the insurance company in your county listed on pages 14 and 15 using the postage-paid envelope included.



❶ Tell us who you are and where you live (person completing this application).

Last Name (Parent/Guardian/Head of Household)	First Name		Middle Initial
Street Address			Apt.
City	State	Zip Code	County
Primary Phone Number	Secondary Phone Number		Best time to call
What is your primary language? ❑ English ❑ Spanish ❑Other (specify) ______ ¿Qué es su idioma primario? ❑ Español ❑ Inglés ❑ Otro (especifique) ______			E-mail Address

❷ Please list all the people who live in your household. Start with yourself.

Please include all adults and children who live with you. START WITH YOURSELF (Last Name, First Name, M.I.)	Are you applying for this person?	Sex:	Is this person:	Birth Date MM/DD/YYYY	Social Security Number
Yourself	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #2	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #3	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #4	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #5	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #6	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		
Person #7	❑ Yes ❑ No	❑ M ❑ F	❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed		

If you need more space please attach a separate sheet of paper.

❷ Please list all the people who live in your household. Start with yourself. (continued)

Is anyone who lives with you a stepparent?	❑ Yes	❑ No
Do the stepchildren live with you?	❑ Yes	❑ No
If yes, tell us: Stepparent's name:	Stepparent for which child(ren)?	
Stepparent's name:	Stepparent for which child(ren)?	

		Race (optional)							Ethnicity (optional)	
Is this person a student under age 19?	How is this person related to you?	African American	Asian (Indian Subcontinent)	Native Alaskan/ American Indian†	Asian	Caucasian	Other (write in)	Native Hawaiian/ Pacific Islander	Hispanic	Non-Hispanic
❑ Yes ❑ No	Self	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑
❑ Yes ❑ No	❑ Child ❑ Stepchild ❑ Spouse ❑ Other ______	❑	❑	❑	❑	❑	❑	❑	❑	❑

†Please submit proof or documentation of membership, if applicable.

❷ Please list all the people who live in your household. Start with yourself. *(continued)*

Citizenship and Identity: If you are a U.S. Citizen:

Name on Birth Certificate (First and Last Name)	If born outside of Pennsylvania, please specify where			Mother's Full Maiden Name (First and Last Name)	Driver's License or State ID (if applicable)	
	State/Territory of Birth	County/Parish of Birth	City of Birth		State/ Territory	Number
Yourself						
Person #2						
Person #3						
Person #4						
Person #5						
Person #6						
Person #7						

Is anyone applying who is not a U.S. Citizen? ❑ Yes ❑ No
If yes, fill in the following information and include copies of INS documents (front and back).

Name of Person Who Is Not a U.S. Citizen	Date Entered the U.S. (MM/DD/YYYY)	From Which Country	Alien Registration Number (A-number)	INS Document (need copy of document, front and back)
Yourself				
Person #2				
Person #3				
Person #4				
Person #5				
Person #6				
Person #7				

❸ Income and Expenses

Please tell us about the income of any child or adult you have listed on this application. You must send us proof of income.

3a. Earned Income includes income from a job or self-employment. You must send us proof of income, for example, a single pay stub for a person who routinely receives the same amount of wages each pay period is acceptable. If your income changes regularly, send us more income documents. All income documents must be dated within the past 60 days (except tax returns). Send copies — we cannot send originals back to you. Add an additional sheet of paper for additional earned incomes.

Does anyone have income from:
Employment (wages, tips, commissions, bonuses) ❑ Yes ❑ No If yes, please fill out the following fields:

Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, monthly, etc.)
Does this income change (for example, overtime, seasonal, etc.)? If yes, please explain. ❑ Yes ❑ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of months worked per year:

Does anyone have income from:
Employment (wages, tips, commissions, bonuses) ❑ Yes ❑ No If yes, please fill out the following fields:

Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, monthly, etc.)
Does this income change (for example, overtime, seasonal, etc.)? If yes, please explain. ❑ Yes ❑ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of months worked per year:

Does anyone have income from:
Employment (wages, tips, commissions, bonuses) ❑ Yes ❑ No If yes, please fill out the following fields:

Whose income is this?	
Employer's Name:	How often is the income received? (weekly, bi-weekly, monthly, etc.)
Does this income change (for example, overtime, seasonal, etc.)? If yes, please explain. ❑ Yes ❑ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of months worked per year:

Does anyone have income from:
Self Employment (Including babysitting or rent paid to you) ❑ Yes ❑ No
If yes, please fill out the following fields:

Whose income is this?	How often is the income received? (weekly, bi-weekly, monthly, etc.)
Does this income change (for example, overtime, seasonal etc.)? If yes, please explain. ❑ Yes ❑ No	Amount received before taxes and deductions (gross amount):
Number of hours worked per month:	Number of months worked per year:

❸ Income and Expenses *(continued)*

3b. Dependent Day Care Expenses

Who is in day care?	How much is paid each month?	How many months each year?	Who in the home pays for this care?

3c. Transportation Expenses

1. How much does it cost you to get to work each week if you ride with another person or take a bus, subway, or trolley?
2. If you drive to work, how many miles do you drive each week?
3. If you are paying for a car, how much is your monthly payment?

3d. Unearned Income: Includes income from retirement/pension plans, worker's compensation, social security, child support payments, and unemployment benefits. You must send us proof of income. Send copies — we cannot send originals back to you. Add an additional sheet of paper for additional unearned incomes.

Does anyone have income from: (Please check Yes or No).	Yes	No	Whose income is this?	How often is the income received? (weekly, bi-weekly, monthly, etc.)	Amount received before taxes and deductions	Does this income change? Yes	Does this income change? No
Supplemental Security Income (SSI)	❑	❑				❑	❑
Pension/Retirement	❑	❑				❑	❑
Workers' Compensation	❑	❑				❑	❑
Unemployment Benefits	❑	❑				❑	❑
Dividends/Interest	❑	❑				❑	❑
Child Support/Alimony	❑	❑				❑	❑
Public Assistance	❑	❑				❑	❑
Social Security (retirement, survivors, disability)	❑	❑				❑	❑
Rental Property (You pay someone to manage.)	❑	❑				❑	❑
Other (Specify)	❑	❑				❑	❑

❹ Health Insurance

Health Insurance from Your Employer

Medical Assistance can sometimes pay bills that your other health insurance doesn't cover. Please provide information for yourself and everyone listed in this application. Indicate if each person has private health insurance today and if he or she had it in the past.

4a. Current Health Insurance: Does anyone you are applying for have **other health insurance today?**

❑ Yes (If yes, please tell us all you can about the insurance in the box below).*
❑ No (If no, answer question 4b).

Insurance Company/Insurer:	List who is covered: First name	Last name
Who holds this policy?	First name	Last name
Policy Number	First name	Last name
Group Number/Name	First name	Last name

What is covered? ❑ Dental ❑ Hospital/Nursing Home ❑ Medical Assistance ❑ Doctor/Outpatient ❑ Medicare Part A Other_____ ❑ Drugs (prescription) ❑ Medicare Part B ❑ Eye Care ❑ Medicare Part D

When did the insurance start? (mm/dd/yyyy)	When will this insurance stop? (mm/dd/yyyy) (Leave blank if the insurance is not ending)

Will this health insurance end because the policy holder lost employment? ❑ Yes ❑ No

If yes, who will lose coverage?

4b. Past Health Insurance: Has anyone you are applying for had **other health insurance within the last six months from the date of the application?**

❑ Yes (If yes, please tell us all you can about the insurance in the box below.)*
❑ No (If no, answer question 4c.)

Insurance Company/Insurer:	List who is covered: First name	Last name
Who holds this policy?	First name	Last name
Policy Number	First name	Last name
Group Number/Name	First name	Last name

What is covered? ❑ Dental ❑ Hospital/Nursing Home ❑ Medical Assistance ❑ Doctor/Outpatient ❑ Medicare Part A Other_____ ❑ Drugs (prescription) ❑ Medicare Part B ❑ Eye Care ❑ Medicare Part D

When did the insurance start? (mm/dd/yyyy)	When did/will this insurance stop? (mm/dd/yyyy) (Leave blank if the insurance is not ending)

Did this health insurance end because the policy holder lost employment? ❑ Yes ❑ No

If yes, who lost coverage?

4c. Pre-Existing Condition: Has anyone in the household been denied full or partial health insurance due to a pre-existing condition (such as asthma, diabetes, or past illnesses or injuries)? This will not affect eligibility for CHIP or Medical Assistance.
❑ Yes ❑ No

If yes: List each person who has been denied due to a pre-existing condition and list the condition.*

*If you need more space, please attach a separate sheet of paper.

❹ Health Insurance *(continued)*

4d. Health Insurance from Your Employer: Medical Assistance can sometimes buy health insurance for you or your child from your employer. Please help us decide if this is possible by completing this section (please check Yes or No).

Can you get health insurance for yourself through your work?	❑ Yes ❑ No
Can you get health insurance for your children through your work?	❑ Yes ❑ No
In the last 30 days, did anyone in your family lose a job where he or she had health insurance?	❑ Yes ❑ No

❺ Special Qualifying Information

If someone you are applying for has a disability or a special health care need, a higher income limit can be used when your family applies for Medical Assistance. Additional services are available. Please help us find out if anyone you are applying for is eligible for these programs.

Pregnancy

Are you, or is anyone who lives with you, pregnant?

❑ Yes ❑ No If yes, tell us who.

Name:	Due date:
Name:	Due date:
Name:	Due date:

Disability

Do you or does anyone you are applying for have a permanent disability, a chronic condition, or an ongoing health care need?

❑ Yes ❑ No If yes, tell us who, and about their needs.

Name:
What is the disability or condition?
Date condition/disability was diagnosed:
Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No

Name:
What is the disability or condition?
Date condition/disability was diagnosed:
Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No

Name:
What is the disability or condition?
Date condition/disability was diagnosed:
Has this person applied for disability benefits? (Social Security disability, Supplemental Security Income, workers' compensation, private disability insurance, or special assistance with medical bills?) ❑ Yes ❑ No

❻ Optional Information

None of this information will affect your application for health care coverage.

Help with Child Support and Health Insurance If you are eligible for Medical Assistance, you may be able to get help with child support payments and with health insurance for your child if he or she has a parent who does not live with you. Please complete the section below. Your children can still receive health care coverage if you do not complete this section.

Name of absent parent:		❑ Check if deceased
Absent parent's address:		
City:	State:	Zip:
Date of birth:	Social Security number:	
Which child(ren) is/was this parent responsible for?		

❻ Optional Information *(continued)*

Name of absent parent:		❑ Check if deceased
Absent parent's address:		
City:	State:	Zip:
Date of birth:	Social Security number:	
Which child(ren) is/was this parent responsible for?		

General Information Please help us help other families by answering these questions.

Where did you learn about CHIP and Medical Assistance? (You can check more than one box.)

- ❑ County Assistance Office
- ❑ Child's school
- ❑ Doctor's office
- ❑ 1-800-986-KIDS Helpline
- ❑ Friend or neighbor
- ❑ TV
- ❑ CHIP Website
- ❑ Other ____________________
- ❑ A local community organization
- ❑ CHIP (PA Insurance Department)
- ❑ Family member
- ❑ Hospital
- ❑ Work
- ❑ Radio
- ❑ Pharmacy

Did your child(ren) have health insurance in the past 6 months? ❑ Yes ❑ No
If yes, please tell us if they lost their health insurance because:

- ❑ My job or other parent's job stopped providing health insurance for my child(ren).
- ❑ My job or other parent's job raised the cost of health insurance for my child(ren).
- ❑ I or other parent no longer have a job.
- ❑ The health insurance was too expensive.
- ❑ My child(ren) can no longer get health insurance through a child support order.
- ❑ Other reason: ______________________________

Primary Care Physician (PCP) or Practice Information: Please list the doctor/provider each person who is applying uses. If you want to check to see if your doctor participates, please call the insurance company with which you wish to apply.

Is the PCP the same for all children? ❑ Yes ❑ No If no, list for each child.

Name(s)	Current Patient?	Physician/Practice Name	Physician/Practice Address	Physician/Practice Telephone Number
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			
	❑ Yes ❑ No			

Please sign and date the next page so your application can be processed.

❼ You have certain rights and responsibilities. They are:

CHIP:

- Confidentiality – All information on this application will be kept confidential. This application will be shared only with the programs for which you apply and/or may be eligible, such as the Medical Assistance program.
- Designate a Personal Representative – You may select another person to receive health related information regarding you or your minor child(ren) by completing a Personal Representative Designation form.
- Certificate of Creditable Coverage – When you leave the program, you will receive a certificate of creditable coverage to verify medical coverage, if you are eligible.
- Written Notice – You will be given a written notice explaining your eligibility.
- Appeal – You may request an impartial review if you do not agree with any decision made regarding this application, if the request is made within 30 days of the decision.

You have a responsibility to:

- Read and fully understand this application.
- Provide true, correct and complete information, understanding that there are penalties for knowingly giving false information: it is a serious offense and considered criminal insurance fraud.
- Help with the review of this application, which may include interviews and reviewing health records.
- Be aware that certain information may be subject to verification from employers, financial sources and other third parties.
- Provide proof of identity and U.S. citizenship if that information is not obtained through this application process.
- Provide proof of legal immigration status by presenting documentation from the U.S. Citizenship and Immigration Services if you are applying for someone who is not a U.S. Citizen.
- Report all changes regarding your household including income, address and telephone number as soon as they occur.

Medical Assistance:

- I understand that the information on this form will be kept confidential.
- I understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.
- I understand I will receive a written notice explaining the benefits.
- I understand that I can request a hearing if I do not agree with a decision made on this application.
- I understand that my situation is subject to verifications from employers, financial sources and other third parties.
- I understand that Medical Assistance applicants must provide their Social Security number. This number may be used to check the information on this application.
- I understand that I do not have to provide a Social Security number for anyone who is not applying for Medical Assistance. If I do provide their Social Security number, it may be used to check information on this application.
- I understand that I have a right to a certificate of creditable coverage to verify my medical coverage. Federal law limits when health coverage may be denied or limited for a preexisting condition. If I enroll in a group health plan that has a preexisting condition, I can get credit for the time I received Medical Assistance.
- I understand that if some or all of the individuals applying do not qualify for Medical Assistance, they may be eligible for CHIP. If this is the case, then I will allow the Department of Public Welfare to give my name and information on this application to the Insurance Department or the CHIP contractor. I understand my rights and responsibilities under CHIP.

I certify that, to the best of my knowledge, I understand my rights and responsibilities and that the information included in this application is complete and true under penalty of perjury. I also certify that knowingly providing false or incomplete information on this application is insurance fraud.

I understand that all individuals applying will be provided access to coverage under the program for which they are eligible, if they are found eligible for Medical Assistance or CHIP.

I will allow the Pennsylvania Insurance Department to give any and all information found on this application to the Department of Public Welfare if any applicants may be eligible for Medical Assistance.

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the CHIP and Medical Assistance programs.

I certify that the person(s) I am applying for are U.S. citizens or aliens in lawful immigration status. (I understand this certification does not apply to an alien who is applying only for Medical Assistance Emergency Health Care benefits.)

I authorize the release of personal, financial, and medical information for the purpose of determining eligibility and for review of the program(s) for which I am applying.

Signature of Applicant or Person Applying for Applicant(s):

X_____ **Date:** _____

YOU MUST SIGN AND DATE THIS APPLICATION OR IT CANNOT BE PROCESSED!

What Happens Next

After we receive your application, we will do an eligibility review and contact you within 30 days.

If we need more information:

We will send you a letter requesting the extra information that we need. Please send us this information right away so we can process your application.

If you have questions or need help filling out this application, please call us at 1-800-986-KIDS (CHIP).

If your child is eligible for CHIP:

- After we check your income and other information, we will notify you of your child's enrollment date.
- If your child is eligible for *low-cost* CHIP or *full-cost* CHIP, you will receive a bill that must be paid before CHIP coverage can begin.
- You will receive your child's identification card approximately 10 days from the date you become eligible.
- You can begin using your child's CHIP coverage on the "effective date" stated in the enrollment letter.

If your child is not eligible for CHIP:

- We will notify you in writing to let you know why your child is not eligible.
- If your child appears to be eligible for Medical Assistance, we will send your application to the County Assistance Office.

Renewal

If your child is enrolled in CHIP:

- Once a year, on the anniversary of your child's enrollment, your child's eligibility will be reviewed. This process is called renewal. Each year, three months before your family's renewal date, letters will be sent requesting verification of income and other family information. If you do not provide the information needed, your child's CHIP coverage will end.

This managed care plan may not cover all of your health care expenses.
Read all your materials carefully to determine which health care services are covered.

CHIP Companies, listed by county:

ADAMS
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan
UPMC Health Plan

ALLEGHENY
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

ARMSTRONG
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

BEAVER
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

BEDFORD
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

BERKS
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan
UPMC Health Plan

BLAIR
Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

BRADFORD
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

BUCKS
Aetna
UnitedHealthcare Community Plan
Keystone Health Plan East
KidzPartners

BUTLER
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health plan

CAMBRIA
Geisinger Health Plan
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

CAMERON
Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

CARBON
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

CENTRE
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Highmark BC/BS

CHESTER
Aetna
UnitedHealthcare Community Plan
Keystone Health Plan East

CLARION
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

CLEARFIELD
Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

CLINTON
First Priority Health
(BCNEPA)
Geisinger Health Plan

COLUMBIA
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

CRAWFORD
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

CUMBERLAND
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

DAUPHIN
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

DELAWARE
Aetna
UnitedHealthcare Community Plan
Keystone Health Plan East
KidzPartners

ELK
Highmark BC/BS
UPMC Health Plan

ERIE
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

FAYETTE
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

FOREST
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

FRANKLIN
Aetna
Capital BlueCross
Highmark Blue Shield

FULTON
Aetna
Capital BlueCross
Highmark Blue Shield

GREENE
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

HUNTINGDON
Geisinger Health Plan
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

INDIANA
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

JEFFERSON
Geisinger Health Plan
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

JUNIATA
Captial BlueCross
Geisinger Health Plan
Highmark Blue Shield

LACKAWANNA
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

LANCASTER
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

LAWRENCE
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

LEBANON
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

LEHIGH
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan
UPMC Health Plan

LUZERNE
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

LYCOMING
First Priority Health
(BCNEPA)
Geisinger Health Plan

McKEAN
Highmark BC/BS
UPMC Health Plan

MERCER
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

MIFFLIN
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

MONROE
Aetna
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

MONTGOMERY
Aetna
UnitedHealthcare Community Plan
Keystone Health Plan East
KidzPartners

MONTOUR
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

NORTHAMPTON
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan
UPMC Health Plan

NORTHUMBERLAND
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

PERRY
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

PHILADELPHIA
Aetna
UnitedHealthcare Community Plan
Keystone Health Plan East
KidzPartners

PIKE
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

POTTER
Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

SCHUYLKILL
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan

SNYDER
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

SOMERSET
Geisinger Health Plan
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

SULLIVAN
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

SUSQUEHANNA
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

TIOGA
First Priority Health
(BCNEPA)
Geisinger Health Plan

UNION
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

VENANGO
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

WARREN
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

WASHINGTON
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

WAYNE
First Priority Health
(BCNEPA)
Geisinger Health Plan

WESTMORELAND
Highmark BC/BS
UnitedHealthcare Community Plan
UPMC Health Plan

WYOMING
First Priority Health
(BCNEPA)
Geisinger Health Plan
UnitedHealthcare Community Plan

YORK
Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
UnitedHealthcare Community Plan
UPMC Health Plan

Please see the reverse side for contact information and mailing instructions.

With CHIP, you have a choice of companies to administer the health benefits for your child(ren).

Below are the health insurance companies who offer CHIP. Based on the county listings on page 11, please choose the health insurance company in your county you'd like to receive your CHIP coverage through and submit your application to them. Addresses and phone numbers are listed for your convenience. **Be sure to write down the phone number of the company you choose so that you can call them with any questions.**

You may find that there is more than one CHIP insurance company in your county. We can't tell you which company to choose, but we can help you make a decision if you are having trouble deciding. If your child currently has a doctor, contact your doctor's office and find out if he/she participates with the CHIP companies listed below so that you can continue to go to that doctor after you choose the CHIP insurance company. You can also ask people you trust for a doctor they recommend.

AETNA BETTER HEALTH KIDS — CHIP
P.O. Box 14384
Lexington, KY 40512-9854
1-800-822-2447
fax 860-754-1055

CAPITAL BLUE CROSS
P.O. Box 777014
2500 Elmerton Avenue
Harrisburg, PA 17110-9956
1-800-543-7101
fax: 717-651-8592

FIRST PRIORITY HEALTH (BCNEPA)
Attn: CHIP
19 N Main St.
Wilkes Barre, PA 18711-9989
1-800-543-7199
fax: 570-200-6785

GEISINGER HEALTH PLAN
100 North Academy Avenue
Danville, PA 17822-3220
1-866-621-5235
fax: 570-271-5970

HIGHMARK BLUE SHIELD (CENTRAL PA)
Attn: CHIP
P.O. Box CARING
Pittsburgh, PA 15230-9779
1-800-543-7105
fax: 1-866-308-1253

KEYSTONE HEALTH PLAN WEST
Attn: CHIP
P.O. Box CARING
Pittsburgh, PA 15230-9779
1-800-543-7105
fax: 1-866-308-1253

KEYSTONE HEALTH PLAN EAST
Caring Foundation
1901 Market Street
Philadelphia, PA 19103-9552
1-800-464-5437
fax: 215-241-3679

KIDZ PARTNERS
P.O. Box 1420
Philadelphia, PA 19105-1420
1-888-888-1211
fax: 215-967-9281

UPMC HEALTH PLAN
P.O. Box 2875
Pittsburgh, PA 15230
1-800-978-8762
fax: 412-454-5937

XEROX UNIPRISE PROJECT
ATTN: UnitedHealthcare Community Plan of PA
3315 Central Ave.
Hot Springs, AR 71913
1-800-414-9025
fax: 866-888-1129