TEXAS
Health and Human
Services Commission

Date/Fecha
Eligibility Specialist/Especialista de Elegibilidad
Office Address and Telephone No./Oficina y Teléfono

(Name and Address of Verifying Insurance Company)

VERIFICATION OF HEALTH INSURANCE POLICY

The following person is being considered for medical assistance. The requested health policy information, as well as information about any additional policies, will assist me in arriving at a determination. A signed authorization to release information is enclosed. Your prompt response will be appreciated.

Policy Number	Owner of Policy	Social Security No.
Name of Insured (if different from owner)		Social Security No.

Comments:

TO BE COMPLETED BY INSURANCE COMPANY REPRESENTATIVE:	Policy No.	Policy No.	Policy No.
Premium Amount	$	$	$
When Paid? (monthly, quarterly, yearly)			
Begin Date			
End Date (if lapsed)			
Type Coverage			
Prescription Drug Coverage?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Medicare Skilled Facility?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Other Nursing Home Coverage?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**
Assignable to Providers?	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**	☐ **Yes** ☐ **No**

Address for Claims:

Telephone No. (include area code)

Signature

Date