

Health Care in Pennsylvania.
Easy, affordable protection for your family.

Application for Health Care Coverage

This application may be used by families with children who apply for health care benefits under the Children's Health Insurance Program (CHIP) or the Medical Assistance Program.



Pennsylvania's Children's
Health Insurance Program
We Cover All Kids.

www.chipcoverspakids.com

1-800-986-KIDS

Information about Health Care Coverage

Please note: If you need Medical Assistance benefits for families without children, cash assistance or food stamps, you must complete a different application. Please call your County Assistance Office and they will send you the proper form.

If you need help with this form: Call the Helpline at 1-800-986-KIDS. If you are hearing impaired, call TTY 1-877-232-7640.

Si necesita esta información en español, llame al teléfono: 1-800-986-5437.

Health Care Coverage May Include:

- Checkups
- Sick visits and prescription drugs
- Emergency room care
- Hearing testing and hearing aides
- Immunizations
- Dental care
- Vision testing and eyeglasses
- Lab tests and X-rays
- Mental health and substance abuse treatment
- Durable medical equipment
- Hospital care

Questions You May Have:

Q: Which program can my children enroll in?

A: Whether your children are enrolled in CHIP (Children's Health Insurance Program) or Medical Assistance will depend mostly on your household income and the ages of your children. You may apply to the program of your choice, however, your family circumstance will determine what program your children will be eligible for. This application will work for either program. It is not necessary to fill out this application twice.

- *If you apply first to Medical Assistance but are not eligible, your application will be sent to a CHIP contractor to see if you are eligible.*
- *If you apply first to CHIP but are not eligible, your application will be sent to the County Assistance Office to see if you are eligible for Medical Assistance.*
- *If this happens, you will get a letter telling you what has happened to the application and what to expect.*

Q: How will I know if my family is eligible?

A: You should receive a letter from the program you applied to within 30 days, which will tell you who is eligible for the program and who is not. If someone does not get into the program, the letter will tell you why and what you can do next.

Q: What if someone in my family has a disability or a special health care need?

A: You cannot be turned down for coverage because of a disability or special need. If you or your child has a disability or special health care need, a higher income limit can be used when you apply for Medical Assistance. You may also be able to receive additional services.

Application for Health Care Coverage

*Si necesita esta información en español, llame al teléfono: 1-800-986-5437.
 Usuarios del sistema TTY deben llamar al 1-877-232-7640.*

What language do you prefer? ___ Spanish ___ English ___ Other (specify) _____
 Qué idioma prefiere usted? ___ Español ___ Inglés ___ Otro (especifique) _____

This form can be used to apply for **(CHIP)** or **Medical Assistance**. Enrollment in either program will depend mostly on your household income and the ages of your children. All information you provide on this form is confidential and may be shared between the two programs if necessary.

CHIP: Provides free or low-cost health care coverage for uninsured children and teens up to age 19 who are not eligible for Medical Assistance. There is no waiting list.

Medical Assistance: Provides free health care coverage for children under age 21, pregnant women and other adults who qualify.

How to Apply:

1. Fill out the form and sign it. **Please print.**
2. Attach **proof of all income** your household received during the last 60 days.
 - Proof includes pay stubs, award letters or checks.
 - For wages, make sure to send a pay stub dated within the past 60 days. If your income varies, you can send in more than one pay stub. Also, an employer can write a letter that states what the monthly pay is if there are no pay stubs.
 - If self-employed, copies of tax returns or receipts, or other records count as proof of income.
 - The information you attach should show what the income is *before* taxes and deductions.
3. If you are applying for someone who is not a U.S. citizen, please attach proof of alien status. (You do not need to attach proof of alien status if this is an emergency application for Medical Assistance.)
4. You will find most counties offer a choice of insurance companies. Go to page 11 for the county by county listing, and page 12 for company contact information and mailing addresses.
5. If you need help with this application, please call 1-800-986-KIDS, or if you are hearing impaired call TTY 1-877-232-7640.

I. Tell us who you are and where you live:

Last name (Parent/Caretaker)	First Name	Middle Initial	Email address	
Street Address		City	State	Zip Code
County	Home Phone	Work Phone		Best time to call

II. Please list the people who live with you. Start with yourself:

Last name, First name, Middle initial:	Are you applying for this person?	Sex	Is this person:	Birth date: MM/DD/YY	Social Security Number:	Is this person a student under age 19?	How is this person related to you?	Is this person a U.S. citizen?
Yourself	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	Self	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 2	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 3	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 4	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 6	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 7	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Person 8	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Widowed	___/___/___		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Child <input type="checkbox"/> Stepchild <input type="checkbox"/> Spouse <input type="checkbox"/> Other:	<input type="checkbox"/> Yes <input type="checkbox"/> No

Are you, or is anyone who lives with you a stepparent? **Yes** **No**
(If **No**, skip to section III.)

Do the stepchildren live with you? **Yes** **No**

If **Yes**, tell us:

Stepparent's name: _____

Stepparent for which child/children? _____

Stepparent's name: _____

Stepparent for which child/children? _____

III. Income and Expenses

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

Be sure to send copies of all income documents with your application!

Does anyone have income from: (please check Yes or No)	Yes	No	Whose income is this?	How often is the income received? <i>(weekly, bi-weekly, monthly, etc.)</i>	Amount of monthly income before taxes and deductions:	Hours worked per month:	Months worked per year:
Employment							
Employer's Name							
Employment							
Employer's Name							
Self-Employment <i>(Including babysitting & room and board paid to you)</i>							
Social Security Income							
Supplemental Security Income (SSI)							
Pension/Retirement							
Workers' Compensation							
Unemployment Benefits							
If Yes to Unemployment Benefits, date benefits started							
Dividends/Interest							
Child Support/Alimony							
Public Assistance							
Other <i>(Specify)</i>							

Some of your expenses can help make you eligible. Please tell us what you pay for child care and adult care, and what you pay for transportation to go to work.

Child Care & Adult Care Expenses

Name of child or disabled adult:	Monthly expense amount:

Transportation Expenses

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?

If you drive to work, how many miles do you drive each week?

If you have a car, how much is your monthly payment?

IV. Health Insurance

Medical Assistance can sometimes pay bills that your health insurance doesn't cover. If you or someone you are applying for has health insurance, please complete this section.

Does anyone you are applying for have private health insurance now? **Yes** **No**

Has anyone you are applying for had private health insurance within the last six months? **Yes** **No**

Have you, your spouse or children lost health insurance coverage because either you or your spouse is no longer employed? **Yes** **No**

If yes, who lost coverage? _____

If you answered **Yes** to any of the questions above, please fill in the next section and tell us all you can about the insurance.*

- If you have or had more than one kind of insurance, please fill in a box for each policy.
- If more than one person has or had insurance, please fill in a box for each person.

Insurance Company	Who holds this policy?
Who is covered?	What is covered? <input type="checkbox"/> hospital care <input type="checkbox"/> prescriptions <input type="checkbox"/> vision <input type="checkbox"/> doctor's visits <input type="checkbox"/> dental <input type="checkbox"/> other
Policy number	Group number/name
When did this insurance start?	When did or will this insurance stop? <i>(Leave blank if it is not ending.)</i>

Insurance Company	Who holds this policy?
Who is covered?	What is covered? <input type="checkbox"/> hospital care <input type="checkbox"/> prescriptions <input type="checkbox"/> vision <input type="checkbox"/> doctor's visits <input type="checkbox"/> dental <input type="checkbox"/> other
Policy number	Group number/name
When did this insurance start?	When did or will this insurance stop? <i>(Leave blank if it is not ending.)</i>

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

Has anyone you are applying for been denied full or partial private health insurance coverage due to a pre-existing condition (such as asthma, diabetes or past injuries)? **Yes** **No**

If yes, please list the name(s) of the person(s) denied coverage due to a pre-existing condition (this will not affect eligibility for CHIP or Medical Assistance): _____

Car Insurance

Car insurance will often pay for injuries that occur in an accident. Medical Assistance will pay for only what the car insurance doesn't cover. Do you have car insurance? **Yes** **No**

If **Yes**, please fill in the next section. If **No**, please leave it blank.

Insurance company name:	Who holds this policy?
Policy Number:	Policy expiration date:

Health Insurance from Your Employer

Medical Assistance can sometimes buy health insurance for you or your children from your employer. Please help us decide if this is possible by completing this section.

Please check Yes or No	Yes	No
Can you get health insurance for yourself through your work?		
If Yes, would you have to pay for it?		
Can you get health insurance for your children through your work?		
If Yes, would you have to pay for it?		
In the last 30 days, has anyone in your family lost a job where they had health insurance?		

V. Special Qualifying Information

If someone you are applying for has a disability, a chronic condition, an ongoing special health care need or a need for health sustaining medication, 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.

Are you, or is anyone who lives with you, pregnant? **Yes** **No** If **Yes**, tell us who:

Name: _____

Due Date: _____

Name: _____

Due Date: _____

Do you, or does anyone who lives with you, have a disability, a chronic condition, an ongoing special health care need or a need for health sustaining medication **Yes** **No**
If **Yes**, tell us who, and about their needs:

Name: _____ Disability or condition (optional): _____

Name: _____ Disability or condition (optional): _____

Did anyone receive Supplemental Security Income (SSI) in the past? **Yes** **No**
(If **No**, skip this section.)

If **Yes**, name of individual who received SSI in the past: _____

If SSI was stopped, was it because he or she began to get Social Security? **Yes** **No**

If SSI was stopped, was it because he or she got an increase in Social Security? **Yes** **No**

Help with Unpaid Medical Bills

You may be able to get help from Medical Assistance for unpaid medical bills from the last three months.

Do you have any unpaid medical bills for anyone you are applying for? **Yes** **No**

If **Yes**, please give us copies of the bills and proof of income for those months.

VI. Optional Information

None of these answers will affect your application for health care.

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		<input type="checkbox"/> Check if deceased	
Absent Parent's Street Address		City	State
Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?	

Name of absent parent		<input type="checkbox"/> Check if deceased	
Absent Parent's Street Address		City	State
Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?	

Name of absent parent		<input type="checkbox"/> Check if deceased	
Absent Parent's Street Address		City	State
Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?	

Name of absent parent		<input type="checkbox"/> Check if deceased	
Absent Parent's Street Address		City	State
Date of Birth	Social Security Number	Which child(ren) is/was this parent responsible for?	

Optional Information *(continued)*

Please help us help other families by answering these questions:

How did you learn about CHIP and/or Medical Assistance? (check all boxes that apply)

Through CHIP	At my doctor's office	Through my child's school
The 1-800-986-KIDS helpline	At the hospital	Through a family member
On TV	Through my work	Through a family friend
On the radio	CHIP Web site	At the County Assistance Office
Through a local organization	Pharmacy	Other _____

Did your children have health insurance in the past six months? **Yes** **No**

If **Yes**, please tell us why they lost their health insurance:

- My job stopped providing health insurance for my children
- My job raised the cost of health insurance for my children
- The health insurance was too expensive
- My children no longer have health insurance through a child support order
- I, or other parent no longer have a job
- Other: _____

What school district do you live in? _____

Name	Race <i>(check all that apply)</i>		Ethnicity
Yourself	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 2	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 3	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 4	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 5	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 6	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 7	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic
Person 8	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	Hispanic
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander	
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)	Non-Hispanic

VII. You have certain rights and responsibilities. They are:

CHIP:

- I have read and fully understand this application. The information that I have given is true and correct.
- I understand that there may be penalties for knowingly giving false information.
- I understand that if some or all of my children do not qualify for CHIP, they may qualify for Medical Assistance. If this is the case, I will allow CHIP to give my name and the information on this application to the Department of Public Welfare.
- I agree to help in the review of the CHIP program. I understand this may include interviews, and a review of my child's health records and application form.

Medical Assistance:

- I understand that the information on this form will be kept confidential.
- 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 understand that I must report all changes in my household or financial situation to the County Assistance Office within one week.
- 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 verification 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 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 pre-existing condition clause, I can get credit for the time I received Medical Assistance.
- I certify that all information on this application is true under penalty of perjury.
- I certify, to the best of my knowledge, that I understand my rights and responsibilities.

Be sure to sign the application and include copies of proof of income!

Signature of applicant or person applying for applicant(s):

Sign here: _____ Date: _____

Certification of Citizenship or Alien Status

By signing my name below, I certify that the persons that I am applying for are U.S. citizens or aliens in lawful immigration status. I know I must sign this in order to be eligible for CHIP or Medical Assistance under law. *(An alien who is applying only for Medical Assistance emergency health benefits does not have to sign this certification.)*

Sign Here: _____ Date: _____

For Office Use Only:

Source of application: ___ Helpline ___ CAO ___ CHIP contractor (specify) _____		___ Other (specify)
Date received: ___ / ___ / ___	Categories: _____	
File cleared by date: ___ / ___ / ___	Screened by date: ___ / ___ / ___	
AP registration : _____	Provider #: _____	
County: _____	District: _____	Record #: _____
<input type="checkbox"/> Authorized <input type="checkbox"/> Not Authorized		Reason Code: _____

CHIP Companies, listed by county:

ADAMS

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

ALLEGHENY

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

ARMSTRONG

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

BEAVER

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

BEDFORD

Highmark BC/BS
Unison Kids
UPMC Health Plan

BERKS

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

BLAIR

Aetna
Geisinger Health Plan
Highmark BC/BS
Unison Kids
UPMC Health Plan

BRADFORD

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

BUCKS

Aetna
AmeriChoice
Keystone Health Plan East

BUTLER

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

CAMBRIA

Aetna
Geisinger Health Plan
Highmark BC/BS
Unison Kids
UPMC Health Plan

CAMERON

Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

CARBON

Aetna
First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

CENTRE

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

CHESTER

Aetna
AmeriChoice
Keystone Health Plan East

CLARION

Aetna
Highmark BC/BS
Unison Kids
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
Unison Kids

CRAWFORD

Highmark BC/BS
Unison Kids
UPMC Health Plan

CUMBERLAND

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

DAUPHIN

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

DELAWARE

Aetna
AmeriChoice
Keystone Health Plan East

ELK

Highmark BC/BS
UPMC Health Plan

ERIE

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

FAYETTE

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

FOREST

Highmark BC/BS
Unison Kids
UPMC Health Plan

FRANKLIN

Aetna
Capital BlueCross
Highmark Blue Shield
Unison Kids

FULTON

Aetna
Capital BlueCross
Highmark Blue Shield

GREENE

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

HUNTINGDON

Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

INDIANA

Highmark BC/BS
Unison Kids
UPMC Health Plan

JEFFERSON

Aetna
Geisinger Health Plan
Highmark BC/BS
Unison Kids
UPMC Health Plan

JUNIATA

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

LACKAWANNA

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

LANCASTER

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

LAWRENCE

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

LEBANON

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

LEHIGH

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

LUZERNE

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

LYCOMING

First Priority Health
(BCNEPA)
Geisinger Health Plan

McKEAN

Highmark BC/BS
UPMC Health Plan

MERCER

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

MIFFLIN

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

MONROE

Aetna
First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

MONTGOMERY

Aetna
AmeriChoice
Keystone Health Plan East

MONTOUR

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

NORTHAMPTON

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

NORTHUMBERLAND

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

PERRY

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

PHILADELPHIA

Aetna
AmeriChoice
Keystone Health Plan East
KidzPartners

PIKE

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

POTTER

Geisinger Health Plan
Highmark BC/BS
UPMC Health Plan

SCHUYLKILL

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

SNYDER

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

SOMERSET

Aetna
Geisinger Health Plan
Highmark BC/BS
Unison Kids
UPMC Health Plan

SULLIVAN

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

SUSQUEHANNA

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

TIOGA

First Priority Health
(BCNEPA)
Geisinger Health Plan

UNION

Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield

VENANGO

Highmark BC/BS
Unison Kids
UPMC Health Plan

WARREN

Highmark BC/BS
Unison Kids
UPMC Health Plan

WASHINGTON

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

WAYNE

First Priority Health
(BCNEPA)
Geisinger Health Plan

WESTMORELAND

Aetna
Highmark BC/BS
Unison Kids
UPMC Health Plan

WYOMING

First Priority Health
(BCNEPA)
Geisinger Health Plan
Unison Kids

YORK

Aetna
Capital BlueCross
Geisinger Health Plan
Highmark Blue Shield
Unison Kids

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

930 Harvest Drive
PO BOX 937, U32N
BLUE BELL, PA 19422
1-800-822-2447

AMERICHOICE

CHIP Plan – Enrollment Application
Attn: Enrollment Department
PO Box 6300
Eau Claire, WI 54701
1-877-289-1917

CAPITAL BLUE CROSS

PO Box 777014
2500 Elmerton Avenue
Harrisburg, PA 17110-9956
1-800-543-7101

FIRST PRIORITY HEALTH (BCNEPA)

Attn: CHIP/adultBasic
19 N Main St.
Wilkes Barre, PA 18711-9989
1-800-543-7199

GEISINGER HEALTH PLAN

100 North Academy Avenue
Danville, PA 17822-3220
1-866-621-5235

HIGHMARK BLUE SHIELD

Attn: CHIP
PO Box 890175
Camp Hill, PA 17001-9705
1-866-727-5437

HIGHMARK BLUE CROSS BLUE SHIELD

PO Box Caring
Pittsburgh, PA 15230-9779
1-800-543-7105

KEYSTONE HEALTH PLAN EAST

Caring Foundation
1901 Market Street
Philadelphia, PA 19103-9552
1-800-464-5437

KIDZ PARTNERS

PO Box 1420
Philadelphia, PA 19105-1420
1-888-888-1211

UNISON KIDS

Unison Administrative Services, LLC.
Unison Plaza
1001 Brinton Road
Monroeville, PA 15221
1-800-414-9025

UPMC HEALTH PLAN

PO Box 2875
Pittsburgh, PA 15230
1-800-978-8762