

**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](http://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 <b>Yes</b> or <b>No</b> )	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 &amp; room and board paid to you)</i>							
Social Security Income							
Supplemental Security Income (SSI)							
Pension/Retirement							
Workers' Compensation							
Unemployment Benefits							
If <b>Yes</b> 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 <b>Yes</b> or <b>No</b>	<b>Yes</b>	<b>No</b>
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	Zip
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	Zip
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	Zip
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	Zip
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	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 2	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 3	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 4	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 5	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 6	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 7	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		
Person 8	<input type="checkbox"/> African American	<input type="checkbox"/> Native Alaskan/American Indian	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
	<input type="checkbox"/> Asian	<input type="checkbox"/> Native Hawaiian/Pacific Islander		
	<input type="checkbox"/> Caucasian	<input type="checkbox"/> Asian (Indian subcontinent)		

## 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  
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  
UPMC Health Plan

## BERKS

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## BLAIR

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## BRADFORD

Blue Cross of NEPA  
Unison Kids

## BUCKS

Aetna  
AmeriChoice  
Keystone Health  
Plan East

## BUTLER

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health plan

## CAMBRIA

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## CAMERON

Highmark BC/BS  
UPMC Health Plan

## CARBON

Aetna  
Blue Cross of NEPA  
Unison Kids

## CENTRE

Capital BlueCross  
Highmark Blue Shield  
Highmark BC/BS

## CHESTER

Aetna  
AmeriChoice  
Keystone Health  
Plan East

## CLARION

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## CLEARFIELD

Highmark BC/BS  
UPMC Health Plan

## CLINTON

Blue Cross of NEPA

## COLUMBIA

Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## CRAWFORD

Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## CUMBERLAND

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## DAUPHIN

Aetna  
Capital BlueCross  
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

Highmark BC/BS

## INDIANA

Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## JEFFERSON

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## JUNIATA

Capital BlueCross  
Highmark Blue Shield

## LACKAWANNA

Blue Cross of NEPA  
Unison Kids

## LANCASTER

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## LAWRENCE

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## LEBANON

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## LEHIGH

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## LUZERNE

Blue Cross of NEPA  
Unison Kids  
**LYCOMING**  
Blue Cross of NEPA

## McKEAN

Highmark BC/BS  
UPMC Health Plan

## MERCER

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## MIFFLIN

Capital BlueCross  
Highmark Blue Shield

## MONROE

Aetna  
Blue Cross of NEPA  
Unison Kids

## MONTGOMERY

Aetna  
AmeriChoice  
Keystone Health  
Plan East

## MONTOUR

Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## NORTHAMPTON

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## NORTHUMBERLAND

Capital BlueCross  
Highmark Blue Shield

## PERRY

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## PHILADELPHIA

Aetna  
AmeriChoice  
Keystone Health  
Plan East

## PIKE

Blue Cross of NEPA  
Unison Kids

## POTTER

Highmark BC/BS  
UPMC Health Plan

## SCHUYLKILL

Aetna  
Capital BlueCross  
Highmark Blue Shield  
Unison Kids

## SNYDER

Capital BlueCross  
Highmark Blue Shield

## SOMERSET

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## SULLIVAN

Blue Cross of NEPA  
Unison Kids

## SUSQUEHANNA

Blue Cross of NEPA  
Unison Kids

## TIOGA

Blue Cross of NEPA

## UNION

Capital BlueCross  
Highmark Blue Shield

## VENANGO

Highmark BC/BS  
UPMC Health Plan

## WARREN

Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## WASHINGTON

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## WAYNE

Blue Cross of NEPA

## WESTMORELAND

Aetna  
Highmark BC/BS  
Unison Kids  
UPMC Health Plan

## WYOMING

Blue Cross of NEPA  
Unison Kids

## YORK

Aetna  
Capital BlueCross  
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

## **BLUE CROSS OF NEPA**

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

## **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  
PO Box 13449  
Philadelphia, PA 19101-9552  
1-800-464-5437

## **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 15230-9911  
1-800-978-8762