STATE OF WASHINGTON
HEALTH CARE AUTHORITY
626 8th Avenue, SE • P.O. Box 45502 • Olympia, Washington 98504-5502

March 28, 2014

TO: Health Care Partners

FROM: Manning Pellanda
Eligibility Policy and Service Delivery/CHIP Director

SUBJECT: Retroactive Washington Apple Health Requests

To better streamline the process of retroactively approving an individual for Washington Apple Health, the Health Care Authority (HCA) has developed a "Retroactive Health Care Coverage Request" form for use by hospitals and medical facilities as well as applicants who apply for MAGI-based medical (family, children, pregnancy, and adults who are not aged, blind or disabled). This form can be submitted with a paper Application for Health Care Coverage (18-001). For applications completed by phone or on the Washington Healthplanfinder at www.wahealthplanfinder.org, it can be submitted separately. This form will assist in the timely processing of claims.

Retroactive health care coverage is a two-step manual process. To help ensure the request is processed timely, the form can be completed at the time of application when the primary applicant/head of household is present. This prevents the HCA from having to send the household a letter requesting the form, which may or may not be returned.

Additionally, the household may have unpaid medical bills with other facilities. If at all possible, inquire with the household on all unpaid medical bills for the retroactive period so they are processed at the same time.

As a reminder, retroactive health care coverage is three months prior to the month of application. For example, if an application is submitted in March, the retroactive months would be December, January, and February.

Should the HCA have any questions on the information provided, additional verification may be requested by mail before eligibility is determined. Requests for retroactive Classic Medicaid (aged, blind, and disabled) will continue to be processed by the Department of Social and Health Services and will not require this form.

Thank you for your patience as we continue to improve our processes. If you have any questions on the process, contact your HCA Regional Representative.

Attachments: Retroactive Health Care Coverage Request form
HCA Area Representative List

cc: MaryAnne Lindeblad, Medicaid Director, HCA
Babs Roberts, Director, CSD, DSHS

Washington State Health Care Authority

Retroactive Health Care Coverage Request form – MAGI Medicaid

Use this form only if the applicant has completed an application for health care coverage.

Primary Applicant / Head of Household Information	
First Name, Middle Initial, Last Name	Date of Birth
DSHS ACES Client ID or ProviderOne ID number	Healthplanfinder Application ID number (if known)

Household Members Needing Retroactive Coverage	
Name	Name
Name	Name

Retroactive Months Needed, Household Income, and Deductions

List the month(s) coverage is needed and the household's gross income and deductions for each month. If the household had no income or deductions for the month, write "none."

***Income we count includes**:* Money from employment, self-employment, unemployment, Social Security, dividend payments, renting out a property, railroad retirement benefits, annuity/pension payments, alimony/spousal support, and per capita distributions from gaming.

Deductions include: Tuition or school-related fees, health savings account contributions, alimony/spousal support, student loan interest, educator expenses, moving costs since January, domestic production activities, penalty on early withdrawal of savings, pre-tax retirement account payments (excluding Roth IRA contributions), or certain claimable business expenses of reservists, performing artists, or fee-basis government officials.

Month 1:	Total Gross Household Income: $	Total Deductions: $
Month 2:	Total Gross Household Income: $	Total Deductions: $
Month 3:	Total Gross Household Income: $	Total Deductions: $

Declaration and Signature

By signing below, I certify under penalty and false swearing that my answers are correct and complete to the best of my knowledge. I also understand the penalties for giving false information or breaking the law.

Signature of Applicant	Date
Signature of Authorized Representative (if applicable)	Date
Authorized Representative (AREP) Name	AREP Organization
AREP Email Address	AREP Phone Number

Return the completed form to the Health Care Authority:

- By fax to 1-866-841-2267; or
- By mail to MEDS, PO Box 45531, Olympia WA 98504-5531.

Washington State Health Care Authority

HCA Area Representatives

Area	Counties	Representative
East	Asotin Ferry Garfield Lincoln Pend Oreille Spokane Stevens Whitman	**Mark Westenhaver** mark.westenhaver@hca.wa.gov 360-725-1324
North Central	Adams Chelan Douglas Grant Okanogan	**Dody McAlpine** dody.mcalpine@hca.wa.gov 360-725-9964
South Central	Benton Columbia Franklin Kittitas Klickitat Walla Walla Yakima	**Karin Kramer** karin.kramer@hca.wa.gov 360-725-0754
North West	Island San Juan Skagit Snohomish Whatcom	**Amy Johnson** amy.johnson@hca.wa.gov 360-725-1240
King	King	**Rebecca Janeczko** rebecca.janeczko@hca.wa.gov 360-725-0752 **Jessie Minier** jessie.minier@hca.wa.gov 360-725-1501
Central West	Clallam Jefferson Kitsap Mason Pierce	**Melissa Rivera** melissa.rivera@hca.wa.gov 360-725-1713
South West	Clark Cowlitz Grays Harbor Lewis Pacific Thurston Skamania Wahkiakum	**Colleen Clifford** colleen.clifford@hca.wa.gov 360-725-1321