INGHAM HEALTH PLAN
PO BOX 30125, LANSING, MI 48909
1-866-291-8691

Dear Ingham Health Plan (IHP) Member,

It is time to renew your Health Plan coverage. **You must complete and return this form by the date listed on the letter you received in the mail or your coverage will end.** If you have any questions, please contact Customer Service at 1-866-291-8691 Monday – Friday 8am to 5pm. Completed forms can be mailed, faxed to 517-394-4549, or emailed to redetermination@ingham.org.

Please complete: **(DO NOT LEAVE ANYTHING BLANK OR FORM MAY NOT BE PROCESSED)**

Member First Name: _____ Member Last Name: _____

Member Address (Must be a street address. No PO boxes accepted): _____

City: _____ State: _____ Zip: _____

Member Date of Birth: _____- _____- _____

Member IHP Number: HPMS _____

Name of parent completing application for minor (if applicable): _____

All yearly gross household income is:
(If no income enter $0)

My household size is:
(Add self, spouse, and dependents)

Yes	No	
		My assigned clinic listed on my IHP card is correct. If no, please list who you see for care:
		I live in Ingham county. If no, what county do you live in?
		IHP is the only health care coverage that I have. If no, what is the name of your coverage? Effective date: _____-_____ -_____
		I want to continue to be a member of IHP. If no, please explain:

My daytime phone number is:	_____- _____ - _____			
My email address is:				
The language I speak and understand best is:	English ☐	Spanish ☐	Arabic ☐	French ☐
	German ☐	Mandarin ☐	Vietnamese ☐	Other: ☐
The language I read and understand best is:	English ☐	Spanish ☐	Arabic ☐	French ☐
	German ☐	Mandarin ☐	Vietnamese ☐	Other: ☐

I understand that:

- If my address, income, or health insurance status changes, I will call Customer Service and inform IHP. If I do not, I may be cancelled from IHP.
- IHP is a limited coverage program, not insurance, and it is my responsibility to know what is covered. This information can be found in the Member Guidebook or by calling Customer Service. The doctor's office may not know what services are covered. If I receive a non-covered service I will be responsible for the bill.
- If a non-covered service is provided by a hospital, I may qualify for a reduction of the bill through the hospital's community benefits/charity care program. It is up to me to contact the hospital to apply for the program(s) and I should do this in advance so I know how much I will be responsible for paying.

I understand that by completing and returning this form, I hereby certify that I have read and understand all of the above. The information I have provided is accurate and I have made any necessary corrections. I understand that Ingham Health Plan requires a periodic renewal and I will need to complete paperwork to remain eligible.