



WashTenaw Health Plan @ Health Services Access
 555 Towner Street, Ypsilanti, MI 48197
 Phone: (734) 544-3050 Fax: (734) 544-6726
 Toll Free Phone: 1-800-440-7548
 Website: <http://whp.ewashtenaw.org>

**FAX COVER SHEET
 FOR ALL APPLICATIONS FROM PROVIDERS**

DATE: _____

FROM (Name & Organization): _____

CONTACT PHONE #: _____ **FAX #:** _____

APPLICANT'S NAME: _____

Please note that we can no longer accept incomplete applications. If the following information is not sent, the application will be returned to the sender. We will start processing the application as soon as we receive a complete application with all necessary information.

STAT* ___ State reason; Application will be processed ASAP retroactive to the 1st of the month.

URGENT* ___ State reason; Application will be processed within 2-3 business days, with eligibility retroactive to the 1st of the month) _____

- ___ Patient needs medications (please attach list of medications)
- ___ Patient needs durable medical equipment; **SPECIFY TYPE:** _____
- ___ Patient needs to see their Primary Care Provider within 30 days
- ___ Patient needs to see a Specialty Care Provider within 30 days
- ___ Other; **DESCRIBE NEEDS** _____

ROUTINE ___ Application will be processed within 30 days. Enrollment will begin the 1st day of the month that the Application was processed.

Applications MUST include the following information:

1. **Proof of Washtenaw County Residency:** Picture ID with a current Washtenaw County address or copy of mail from government agency. We will also accept a utility bill (not a phone bill), or copy of current lease in the patient's name. Only residents of Washtenaw County are eligible for WHP.
2. **Proof of Income:** One of the following items can be provided: copies of pay stubs; unemployment check; Michigan tax return; child support check; SSI check; SSD check; FIA benefit letter, or self-employment letter (if patient says they have no income, we require something in writing stating how the person is being supported, and signed.)
3. **Proof of filing an application with FIA for additional insurance, if applicable:** ER Medicaid, Medicaid, Healthy Kids, Medicare. Proof can be a copy of a signed and date application, copy of the signature page, or a letter from FIA.

- **A copy of Stat or Urgent applications should be faxed to the appropriate Network Administrator: SJMH 734-712-3730 or UMHS 734-615-5878**