Washington State Department of HEALTH

DOH 304-130

MTP APPLICATION

This form is used to verify coverage and estimate patient out-of-pocket costs. Details from this form will be used by the patient, family, and program to inform program participation decisions and payment agreements.

Email this completed form to nbsprog@doh.wa.gov

Patient Information	Coverage Information
Patient Name _____ Parent Name _____ Address (street) _____ Shipping address if different from address above _____ City _____ State _____ Zip_____ Home phone # _____ Work phone # _____ Date of birth _____ Applicable ICD-10-CM diagnosis code(s)	Primary Insurance: Company Name _____ Policy # _____ Group # _____ Phone # _____ Subscriber's name _____ Subscriber's date of birth _____ Subscriber's relationship to patient_____ Secondary Insurance: Company Name _____ Policy # _____ Group # _____ Phone # _____ Subscriber's name _____ Subscriber's date of birth _____ Subscriber's relationship to patient_____

To request this document in another format, call 1-800-525-0127. Deaf or hard of hearing customers, please call 711 (Washington Relay) or email civil.rights@doh.wa.gov.