KAISER PERMANENTE®

WMS FOLDER ID #_____

Retroactive Membership Request Form

Purchaser: Use this form per single family account to request that Kaiser Permanente approve retroactive membership changes that exceed the retroactivity contractual provision. Complete Sections One, Two, and Three. Submit the completed form to your Account Administration Representative (AAR) at the California Service Center (CSC). Please attach the appropriate documentation to substantiate the retroactivity request. See instructions on page 2 before completing this form.

SECTION ONE—PURCHASER INFORMATION	**DATE:**
Purchaser name:	**Purchaser number:** (e.g., 12345-0001) -
Purchaser contact information: **Name:** **Telephone:** ( ) - **Fax:** ( ) - **E-mail address:**	**Address:** **State:** **ZIP code:**
Are you a KPIC purchaser? Yes ☐ **No** ☐ **If yes, which plan type: POS** ☐ **PPO** ☐ **OOA** ☐ (**All others may continue to next box.)**	
Retroactive enrollment(s)? ☐ **Retroactive reinstatement(s)?** ☐ **Retroactive termination(s)?** ☐	**Payment included? YES** ☐ **NO** ☐ **If no, estimated payment/report date:**
Explanation for this retroactivity request:	

SECTION TWO—MEMBER INFORMATION **(Use page 2 if additional space is required)**

Employee (subscriber) name	SSN	Dependent name	SSN	MRN	Action requested	Effective date

SECTION THREE—SIGNATURE REQUIRED FOR CONSIDERATION**

KAISER PERMANENTE RETROACTIVITY REQUEST POLICY

Kaiser Permanente's time limit for retroactive membership changes is the calendar month when the California Service Center receives Group's notice of the change plus applicable retroactivity policy. I hereby request that Kaiser Permanente waive that time limit for the member(s) listed on this form, and I understand that Kaiser Permanente may decline to do so for some or all of these member(s). I confirm that all attached documents in support of this request are true and complete. I understand that I must make payment for all months a subscriber is added retroactively.

Signature: **Date:**

SECTION FOUR – CALIFORNIA SERVICE CENTER USE ONLY			**CSC RECEIPT DATE:**
Team name:	**AAR:**	**Team manager:**	**Operations manager:**
Supporting documentation received? **YES** ☐ **NO** ☐		**Retroactive addition(s)** $ **Retroactive reinstatement(s)** $ **Retroactive termination(s)** $	
Standard exception? YES ☐ **NO** ☐ **Escalation request? YES** ☐ **NO** ☐ **Approved? YES** ☐ **NO** ☐		**Reason code:**	
Approved by (print name):	**Signature:**	**Date:**	
Date purchaser notified: **Date account manager notified:**		**Account manager name:**	
For KPIC purchasers only: Approved YES ☐ **NO** ☐ **Date:** **Reason for denial:** **KPIC representative signature (required for all POS, PPO, and OOA plans):** **Print KPIC representative name:**			

Retroactive Membership Request Form Instructions

1. Please use this form to request a retroactive enrollment, reinstatement or termination outside of your retroactivity contractual provision. Supporting documentation must be provided.
2. Please use one form per family account.
3. Complete Sections One, Two, and Three. The request will not be processed if Section Three is not signed and dated.
4. Fax the form to the AAR assigned to your account along with the supporting documentation. The request may not be processed if the appropriate documentation is not submitted.
5. The AAR assigned to you will provide a written response to your request within seven calendar days from the CSC receipt date of your request.
6. Follow up with the AAR assigned to your account if you have any questions.
7. Use the section below for additional members not listed in Section Two.

Employee (subscriber) name	SSN	Dependent name	SSN	MRN	Action requested	Effective date