P.O. Box 14015
Salem, OR 97309-5032
Voice: 1-800-699-9075
FAX: 503-378-5628
TTY: 711
www.OHP.oregon.gov

# O N E

ONE-<<Lang code>>_7310_<<Reply by date>>
<<Case Name>>
<<Case Street Address1>>
<<Case Street Address2>>
<<Case City>>, <<Case State>> <<Case ZIP>>

**Please reply by: <<reply by date>>**

**Case ID:** <<case #>>

Sample Letter

## Important: Renew OHP for you and your household

<<mail date>>

<<Case name>>,

It is time to renew your household's Oregon Health Plan (OHP) coverage. Once a year, we have to review your information to make sure you still qualify. If you do not renew, your coverage will end.

To renew your coverage, follow the instructions below.

Please respond by **<<mm/dd/yyyy>>**. If you do not respond we will send you a notice telling you the date your coverage will end.

> **Important:** This is your case ID: **<<case#>>**
>
> Please write this number on anything you send us. Without your case number there may be delays.

**How to renew**

- **Online:** Follow the instructions on the pink sheet included in this packet to renew your benefits at **OregonHealthCare.gov**.
- **Mail:** Use the enclosed, postage paid envelope to mail your renewal form to:
  Statewide Processing Center
  PO Box 14015
  Salem, OR 97309
- **Fax:** Use the yellow coversheet included in this packet to fax your documents to 503-378-5628.
- **Phone:** You can call us to give us your information at 1-800-699-9075.

You can get this letter in another language, large print, or another way that is best for you. Call 1-800-699-9075 (TTY 711).

Sample Letter

# OHP Renewal – PART 1

***Please fill circles completely. Do not use X s or ✓ s.*** ***Correct mark:*** ● ***Incorrect marks:*** ⊗ ✓

**1 Is the information below correct?** *Note: Some kinds of income are not counted for OHP eligibility because they are not taxable. They are not listed here and you do not need to report them to us. Examples of non-taxable income are income from child support, veteran's payments, and Supplemental Security Income (SSI).*

O YES. If YES, ***go to #2.***

O NO. If NO, ***complete both Parts 1 and 2 of the OHP Renewal and return them in the postage paid envelope.***

| Name | Date of birth | Monthly income | Monthly tax-deductible expenses | Receiving coverage? |
|---|---|---|---|---|
| <<Person 1>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 2>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 3>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 4>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 5>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 6>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 7>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 8>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 9>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 10>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 11>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 12>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 13>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 14>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 15>> | 22/22/2222 | $22,222 | $22,222 | Y |
| <<Person 16>> | 22/22/2222 | $22,222 | $22,222 | Y |

Sample Letter

# OHP Renewal – PART 1

**2 Have you or anyone in your household had any of the following changes?**

- Added or removed a household member;
- Started a new job, lost a job, or a had a change in income or expenses:
- Tax filing status changes;
- Changes to other health insurance (not OHP coverage);
- Contact information changes (if your address is different than the address listed on this letter, or if your mailing address, phone number or email address have changed);
- Anyone has become pregnant or is no longer pregnant;
- Anyone who is renewing coverage and has a disability that will last more than 12 months **AND/OR** needs assistance with daily activities such as walking, eating and remembering;
- You would like to change your coordinated care organization (CCO).

O YES. If YES, ***complete both Parts 1 and 2 of the OHP Renewal and return them in the postage paid envelope.***

O NO. If NO, ***sign below and return your OHP Renewal – PART 1 form in the postage paid envelope.***

**Read and sign –** *If you have an authorized representative, that person may sign for you. If you are an authorized representative you may sign here only if you and the applicant have completed and signed the Authorized Representative form.*

- I'm signing this renewal form under penalty of perjury. This means I've provided true answers to all the questions on this form to the best of my knowledge. I know I may be subject to penalties or be liable for overpayments under federal law if I provide false or untrue information.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity or disability. I can file a complaint of discrimination by visiting **www.hhs.gov/ocr/office/file**
- By signing this form, I confirm that I have permission from all people in my household to both submit their information and receive communications about their eligibility and enrollment.

| Signature | <<case name>> | Date (MM/DD/YYYY) |
|---|---|---|
| | | |

The OHP Renewal Part 2 document can be found at:
**www.oregon.gov/oha/healthplan/Pages/reapply.aspx**

Sample Letter