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MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

1. POLICYHOLDER INFORMATION

POLICYHOLDER NAME	
POLICYHOLDER SOC. SEC. #	
ADDRESS	
CITY	
STATE, ZIP	TELEPHONE
EMAIL ADDRESS	

2. INSURANCE INFORMATION

INSURANCE NAME
CLAIM MAILING ADDRESS
INS. CITY, STATE, ZIP
INS. TELEPHONE
POLICY NUMBER
POLICY GROUP NUMBER

3. LIST ALL PERSONS THAT CAN BE COVERED UNDER THE POLICY INCLUDING POLICYHOLDER

NAME	BIRTHDATE	MO HEALTHNET ELIGIBLE	MO HEALTHNET ID #	SOC. SEC. #
		☐ YES ☐ NO ☐ APP		
		☐ YES ☐ NO ☐ APP		
		☐ YES ☐ NO ☐ APP		
		☐ YES ☐ NO ☐ APP		
		☐ YES ☐ NO ☐ APP		

4. Are you currently enrolled in this policy? ☐ Yes ☐ No

5. Are your dependents currently enrolled in this policy? ☐ Yes ☐ No

6. Are you currently: ☐ Employed ☐ Unemployed ☐ On family or medical leave

7. Is this policy: ☐ Through an employer ☐ Through a former employer ☐ Privately purchased

8. What is the amount of the premium for: Medical $ _____ Dental $ _____ Vision $ _____

9. Are your premiums: ☐ Payroll deducted ☐ Paid directly to the insurance company ☐ Paid directly to the employer

10. Premiums are paid: ☐ Monthly ☐ Biweekly ☐ Semimonthly ☐ Weekly ☐ Quarterly

11. Next premium due date: _____

12. List employer or former employer's name, address and telephone number:

EMPLOYER NAME			EMPLOYER TELEPHONE
EMPLOYER ADDRESS	CITY	STATE	ZIP

IMPORTANT

YOU MUST PROVIDE: COPIES OF FRONT AND BACK OF INSURANCE IDENTIFICATION CARDS, OPEN ENROLLMENT MATERIALS, SCHEDULE OF BENEFITS OR SUMMARY OF COVERAGE THAT DESCRIBES THE POLICY. ELIGIBILITY FOR THE HIPP PROGRAM CANNOT BE ESTABLISHED WITHOUT THIS INFORMATION.

My signature below guarantees that my answers on this form are correct, true and complete to the best of my knowledge. I authorize insurers or employers to release any information on myself or my dependent(s) needed to determine eligibility for the HIPP program.

SIGNATURE OF POLICYHOLDER		**DATE**
SIGNATURE OF CARE COORDINATOR		TITLE
AGENCY/AFFILIATION	TELEPHONE	DATE

Completed application with a copy of your policy information can be mailed or emailed to this address or given to your Family Support Division Eligibility Specialist to forward.

MO HealthNet Division
ATTN: HIPP Program
P.O. Box 6500
Jefferson City, MO 65102-6500
Phone: 573-751-2005

EMAIL TO:
MHD.HIPP@dss.mo.gov

INSTRUCTIONS FOR COMPLETING THE APPLICATION

The Health Insurance Premium Payment (HIPP) Program pays for the cost of health insurance plans when the Department of Social Services decides it would cost less to buy health insurance to cover medical care than to pay for the care only with Medicaid funds. To be eligible for the Health Insurance Premium Payment (HIPP) program, some or all of the persons covered under an insurance policy must be eligible for Medicaid.

WHO MUST APPLY?

You **must** apply to the HIPP program if all of the following are true:

☑ You or a member of your household is applying for Medicaid or are Medicaid-eligible (excluding spend-down)
☑ You or a member of your household is employed or lost employment within the last thirty days, and
☑ The employer or former employer offers **group** health insurance coverage.

If the Department of Social Services decides the health insurance plan is cost-effective, you **must** participate in the HIPP Program.

Applicants', recipients', parents', guardians' or caretakers' Medicaid benefits may be denied or canceled if the applicant, recipient, parent, guardian or caretaker does not provide information necessary to establish cost effectiveness or does not enroll in a group health insurance plan that the Department determines is cost effective.

WHO CAN CHOOSE TO APPLY?

You can choose to apply to the HIPP program if you or a member of your household is applying for Medicaid or are Medicaid-eligible (excluding spend-down) and have health insurance available from sources **other than employers** (personal policies, credit unions, church affiliations, memberships in organizations, etc.) If the Department determines the health insurance plan is cost effective, Medicaid will pay the premium.

Section 1. List the following information about the **policyholder**. Name, social security number, address, and telephone number. If you do not have a telephone, list a number where you can be reached or a message left.

Section 2. List the name, premium mailing address and telephone number of the insurance company, the policy number and the policy group number for any insurance you currently have or any insurance offered by your employer or some other source. If your employer or former employer **does not** offer group health insurance, write "no insurance available" across section 2, then sign and date the application.

Section 3. List the name and birth date of everyone in your family who can be covered under this policy, including the policyholder. Check one box (Yes or No) to indicate whether the person is currently on Medicaid. If a box is marked yes, write the person's Medicaid identification number (DCN) listed on their Medicaid card. If they have applied for Medicaid and do not know if they are eligible, the APP (for Applied) box should be checked. List the social security number for each individual.

Question 4. Indicate whether you are currently covered by this insurance policy.

Question 5. Indicate whether your spouse or children are currently covered by this policy.

Question 6. Indicate your current employment status.

Question 7. Indicate if this insurance is through your current employer, a former employer (such as a COBRA plan), or an insurance plan you have purchased on your own.

Question 8. Indicate the amount of your share of the premium for medical, dental or vision coverage.

Question 9. Indicate if your premiums are currently paid through payroll deduction, direct payment to the insurance company or direct payment to the employer.

Question 10. List how often a premium payment is due. For example: monthly (once a month), biweekly (every two weeks), semimonthly (twice a month), weekly (once a week), quarterly (every three months).

Question 11. List the date your next premium is due.

Section 12. List your employer or former employer's name, address and telephone number. Employers are contacted to verify payroll deductions, rates, etc.

Signature: Sign and date the application form at the bottom.