HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM APPLICATION

(please type or print clearly)

TELL US ABOUT THE PERSON WHO IS ON MEDI-CAL, HAS AN ILLNESS AND WANTS TO APPLY FOR THE HIPP PROGRAM

NAME ***(last, first, middle):***		
ADDRESS ***(street, city, state, zip code)*****:**		
HOME TELEPHONE NUMBER: ( )	**WORK TELEPHONE NUMBER:** ( )	**CELL TELEPHONE NUMBER:** ( )
MEDI-CAL BENEFICIARY IDENTIFICATION CARD (BIC) NUMBER:	**E-MAIL ADDRESS** ***(optional)*****:**	

TELL US ABOUT YOUR PRIVATE MEDICAL INSURANCE

INSURANCE COMPANY NAME:	**INSURANCE COMPANY TELEPHONE NUMBER:** ( )
INSURANCE COMPANY ADDRESS ***(street, city, state, zip code)*****:**	
BILLING ADDRESS IF DIFFERENT ***(street, city, state, zip code)*****:**	
POLICYHOLDER NAME ***(last, first, middle)*****:**	**POLICYHOLDER DAYTIME TELEPHONE NUMBER:** ( )
POLICYHOLDER ADDRESS ***(street, city, state, zip code)*****:**	
POLICY NUMBER:	**CURRENT PREMIUM AMOUNT:**
GROUP NUMBER:	**POLICY LAPSED ON:**

HOW OFTEN IS POLICY PAID:

❑ Monthly ❑ Quarterly ❑ Other:_____

HOW ARE PREMIUMS CURRENTLY PAID ***(check one)*****:**

❑ Paid ENTIRELY by employer
❑ Paid by policyholder through payroll deduction
❑ Other:
❑ Paid by court-ordered absent parent
❑ Paid by policyholder directly to insurance carrier

TYPE OF COVERAGE YOUR MEDICAL INSURANCE PROVIDES ***(check all that apply)*****:**

❑ Hospital inpatient stays
❑ Hospital outpatient *(lab or therapy)*
❑ Doctor visits
❑ Prescription drugs
❑ Vision
❑ Dental
❑ Long-term care (LTC)
❑ Other:

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Care Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the California Department of Health Care Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services, which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42 USC, Section 552a) your Social Security Number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

AUTHORIZATION: "I hereby authorize the California Department of Health Care Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, which may be used in determining if the California Department of Health Care Services will pay health insurance premiums for continued coverage."

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TELL US ABOUT THE PERSON YOU ARE APPLYING FOR AND ANY FAMILY MEMBERS ON THE SAME MEDICAL INSURANCE POLICY

FAMILY MEMBER	NAME *(last, first, middle)*:	CHECK ALL THAT APPLY:	COVERED BY POLICY?	TYPE OF POLICY (*check one, if applicable)*:	ENROLLED IN *(check all that apply)*:	MEDI-CAL BIC NO.
SELF		❑ Medi-Cal ❑ Medicare ❑ Has an illness	❑ Yes ❑ No ❑ Policyholder ❑ Dependent	❑ Tricare ❑ MRMIP ❑ Medicare HMO	❑ Healthy Families ❑ AIM	
FAMILY MEMBER NO. 1	❑ Spouse ❑ Parent ❑ Child ❑ Other	❑ Medi-Cal ❑ Medicare ❑ Has an illness	❑ Yes ❑ No ❑ Policyholder ❑ Dependent	❑ Tricare ❑ MRMIP ❑ Medicare HMO	❑ Healthy Families ❑ AIM	
FAMILY MEMBER NO. 2	❑ Spouse ❑ Parent ❑ Child ❑ Other	❑ Medi-Cal ❑ Medicare ❑ Has an illness	❑ Yes ❑ No ❑ Policyholder ❑ Dependent	❑ Tricare ❑ MRMIP ❑ Medicare HMO	❑ Healthy Families ❑ AIM	
FAMILY MEMBER NO. 3	❑ Spouse ❑ Parent ❑ Child ❑ Other	❑ Medi-Cal ❑ Medicare ❑ Has an illness	❑ Yes ❑ No ❑ Policyholder ❑ Dependent	❑ Tricare ❑ MRMIP ❑ Medicare HMO	❑ Healthy Families ❑ AIM	

FOR ADDITIONAL FAMILY MEMBERS <u>WITH MEDI-CAL</u>, FILL OUT BELOW OR ATTACH INFORMATION ON A SEPARATE SHEET

Declaration: I declare under penalty of perjury under the laws of the State of California that the answers I have given in this application and the documents provided are true and correct to the best of my knowledge.

Name of Applicant *(print):*	Signature of Applicant/Guardian:	Date:
Name of Policyholder *(print):*	Signature of Policyholder:	Date: