Illinois Department of Public Aid

4(12 Months)

HEALTH INSURANCE PREMIUM PAYMENT (HIPP) REFERRAL

IF YOU HAVE A HIGH COST MEDICAL CONDITION AND GROUP HEALTH INSURANCE AVAILABLE TO YOU YOU ARE REQUIRED TO COMPLETE THIS FORM TO BE ELIGIBLE FOR MEDICAL ASSISTANCE

Case Name_____ Case #_____ Date_____

1. Name of the person with the high cost medical condition_____
   The high cost medical condition is _____

2. Name of person who has (or can enroll in) the health plan_____
   Address_____SSN_____Telephone#_____

3. If the person listed in #2 above is not requesting or receiving medical assistance and would be agreeable to enroll the person listed in #1, check here ☐
   If possible, ask the person listed in #2 to sign and date the authorization below:

I authorize IDPA to obtain, as needed, any information regarding my health insurance coverage which may be used to determine if IDPA will pay part or all of my insurance premium. _____
Signature Date

4. Is available health insurance
   ☐ a group through (check one):
   ☐ current employer ☐ former employer ☐ union membership (Local #_____) ☐ other group

_____
Name and address of current/former employer, union or group Telephone #

☐ an individual policy

_____
Name and address of Insurance Agent Telephone #

5. Name and Address of Insurance Carrier _____Policy#_____

Is insurance:
☐ in force, next premium is due_____
☐ COBRA continuation insurance last day to enroll is_____
☐ available but not applied for, next open enrollment begins_____ends_____

6. What types of services does the health plan cover? (check all that apply)
   ☐ Major Medical ☐ HMO ☐ Prescription drugs

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS YOU MAY HAVE.
(This will help IDPA to determine if they will pay your premiums.)
• insurance plan booklet or policy • medical bills
• explanation of benefits (EOB)

If another health plan is available to you or your family, complete a separate form for each plan.

I authorize the Illinois Department of Public Aid to obtain, as needed, any information regarding my or my family's health condition orinsurance coverage, including benefits and/or payments for medical care, which may be used in determining if IDPA will pay health insurance premiums for continued coverage. If I am or a member of my family is determined to be eligible to participate in HIPP, I authorize health insurance premium notices to be sent directly to IDPA.

_____ _____
Signature of Applicant/Client (**REQUIRED**) Date