STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PROGRAM QUALITY AND INTEGRITY

BUREAU OF PROGRAM INTEGRITY - THIRD PARTY LIABILITY UNIT

Lori A. Weaver
Commissioner

Meredith J. Telus
Director

129 PLEASANT STREET, 2ND FLOOR THAYER BUILDING, CONCORD, NH 03301
603-271-8063 1-800-852-3345 Ext. 8063
Fax: 603-271-8113 TDD Access: 1-800-735-2964
www.dhhs.nh.gov

Application for New Hampshire's Medicaid Health Insurance Premium Payment (HIPP) Program

The Health Insurance Premium Payment (HIPP) program defers medical costs from NH Medicaid program by reimbursing certain Medicaid recipients' or employer-related group health insurance premiums when it is cost effective.

Each applicant must meet all of the program's eligibility requirements; if approved, each case is periodically re-evaluated to determine ongoing HIPP program eligibility. At a minimum, each case is re-evaluated at insurance open enrollment. If information requested at re-evaluation is not received, then HIPP will be terminated. Please note that HIPP is *not* an entitlement program.

Requirements for HIPP:

- NH Medicaid Eligible at time of application
- Current employer group health insurance *coverage* (or access to health coverage through an employer at the time of application)
- Health insurance coverage must not be court-ordered
- The employer group health insurance coverage must be cost effective based on Medicaid costs for services covered (This Medicaid cost is determined using the average total annual Medicaid costs of persons like the applicant, which equates to the monthly Managed Care rate and not the applicant's specific medical history)

You **are not** eligible for HIPP if you are eligible for or enrolled in any of the following:

- Medicare
- Medicare Advantage Plans (Medicare part C)
- Medicare supplement policy plans
- Medicaid Spenddown program
- COBRA
- School-based plan for students while at school
- Indemnity or catastrophic insurance plan that does not cover standard medical benefits
- Insurance plan through the Health Insurance Exchange (Marketplace)

REQUIRED DOCUMENTATION FOR ELIGIBILITY DETERMINATION

Please complete the enclosed HIPP Application Form for you/your children, have the subscriber sign the application, and return **the original signed application** along with the following:

- Copy of all of Medicaid eligible individual's health insurance membership cards for the current benefit year including Medicaid and all other medical, dental, vision, and pharmacy cards, front and back;

- Health insurance premium rate sheet from your employer that includes rates/costs for all levels of plans offered (Employee Only, Employee and Spouse, Employee and Child, Family, etc.) regardless of which option you chose

- Health Insurance Summary of Benefits for the current benefit year (this typically describes what services are covered and not covered, policy limits, co-payments, deductibles, etc.)

- The open enrollment form submitted to your employer for the current benefit year identifying all benefit options that you chose; (this can be sent electronically, if necessary)

- If your share of the premium is payroll deducted, please provide four of your recent pay stubs. Otherwise, please provide a copy of three of the most recent insurance premium invoices; (this can be sent electronically, if necessary)

- Signed "Authorization to Release Protected Health Information" form. In the "Disclose the following information" section, please leave this line blank. This will allow us to work with your insurance company, Doctor's office or employer. The **Period From** date should be one year prior from your current policy and the **Period To** date should be the last day of your current policy End Date. Return the form to us after it has been completed, signed by the subscriber, **and witnessed**.

- Other documents may be required when determining eligibility. If additional documentation is needed, you will be contacted.

Fax or mail your completed application and documents to the address listed below:

Fax Number: **(603) 271-8113**

Mailing Address: **BUREAU OF IMPROVEMENT & INTEGRITY - TPL**
HIPP PROGRAM
129 PLEASANT ST – THAYER BLDG. 2ND FLOOR
CONCORD, NH 03301

This current determination process is for HIPP only. Once a complete packet is received you should receive a preliminary response within thirty (30) days. It remains your responsibility to report any changes in income or employment to your Division of Family Assistance (DFA) caseworker within ten (10) business days, as these changes may affect your Medicaid eligibility. Any changes to insurance must be reported to the HIPP program within ten (10) business days of the change.

If you have any questions or require additional clarification, please contact the HIPP Administrator at 800-852-3345, extension 5218 (in NH only) or (603) 271-5218, or via e-mail at DHHS.ThirdPartyLiabi@dhhs.nh.gov

Sincerely,
Health Insurance Premium Payment Program

Lori A. Weaver
Interim Commissioner

Meredith J. Telus
Director

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HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM APPLICATION

If you have any questions regarding this application or the HIPP Program, please call the HIPP Program Administrator, at either (603) 271-5218 or 1-800-852-3345, ext 5218 (in NH only).

1. MEDICAID MEMBER INFORMATION

☐ Check here if additional recipients are listed in the **Other Recipient Section** (see Question 7 on Page 3)

Member Name _____ DOB _____ Medicaid Id _____

Address _____

Home Telephone _____ Parent's Cellphone # _____

2. Is your health insurance coverage court-ordered (part of a divorce/separation decree)? ☐ Yes ☐ No

3. POLICY TYPE ☐ Individual Non-Group ☐ Group/Employer
☐ COBRA ☐ Health Insurance Exchange (Marketplace)

If you checked any box other than *Group/employer*, please **STOP** application. You **do not** qualify for HIPP.

4. SUBSCRIBER INFORMATION: If you are currently enrolled in health insurance through your employer, please complete this section.

Subscriber Name _____ Relationship _____

Social Security # _____ Date Of Birth _____

Address _____

Email Address _____ Work Number _____

Home Phone _____ Cell Phone _____

5. EMPLOYER INFORMATION

Employer Name: _____

Address: _____

Telephone#_____ Fax:_____

Open Enrollment Period: Start Date: _____ End Date: _____

6. INSURANCE INFORMATION: Please complete the information below if you are currently enrolled in your Employer Sponsored Insurance (ESI).

POLICY TYPES: ☐ MEDICAL ☐ PHARMACY ☐ VISION ☐ DENTAL

☐ **Medical Insurance** Insurance Company: _____

Address: _____

Claims Telephone # _____ Customer Service Telephone # _____

Premium Amount $_____ Frequency of Premium Payment: _____

Policy # _____ Group # _____ Effective Date_____

Name and Tel. Number of Insurance Contact Person (HR/Broker): _____

☐ **Pharmacy Insurance** Insurance Company: _____

Address: _____

Claims Telephone # _____ Customer Service Telephone # _____

Premium Amount $_____ Frequency of Premium Payment: _____

Policy # _____ Group # _____ Effective Date_____

Name and Tel. Number of Insurance Contact Person (HR/Broker): _____

☐ **Vision Insurance** Insurance Company: _____

Address: _____

Claims Telephone # _____ Customer Service Telephone # _____

Premium Amount $_____ Frequency of Premium Payment: _____

Policy # _____ Group # _____ Effective Date_____

Name and Tel. Number of Insurance Contact Person (HR/Broker): _____

☐ **Dental Insurance** Insurance Company: _____

(*NOTE:* Dental is only covered by HIPP if the dental premium cannot be separated from the Medical premium)

Address: _____

Claims Telephone # _____ Customer Service Telephone # _____

Premium Amount $_____ Frequency of Premium Payment: _____

Policy # _____ Group # _____ Effective Date_____

Name and Tel. Number of Insurance Contact Person (HR/Broker): _____

7. Other Recipient Section List everyone in your household, including Medicaid members. (Use extra paper if needed)

Name	Social Security Number (Last 4 digits)	Birth Date	Medicaid ID Number (If applicable)	Relationship to Member (Spouse, child, etc.)	Gender	Enrolled in ESI (Employer Sponsored Insurance) (yes/no)
		/ /				
		/ /				
		/ /				
		/ /				

8. HEALTH SAVINGS/REIMBURSEMENT ACCOUNT

Please indicate if either of the following benefits were offered by your employer and if you chose any of them:

Health Reimbursement Account (HRA):	☐ Not Offered	☐ Offered	☐ Chosen	☐ Not Chosen
Health Savings Account (HSA):	☐ Not Offered	☐ Offered	☐ Chosen	☐ Not Chosen

AUTHORIZATION: I certify, under penalty of perjury, that I have reviewed this information; it is true and complete to the best of my knowledge. I authorize insurers or employers to release any information on myself, or other household member (s) necessary to determine eligibility for the HIPP Program.

Subscriber's Signature: _____ _____
Applicant/Subscriber's Signature Date

_____
Printed Name

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Authorization Form

For the Use and Disclosure of Individually Identifiable Health Information

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

This authorization expires one year from the date that it is signed.

Persons/organizations authorized to use and/or disclose the information:

Department of Health and Human Services, Bureau of Improvement & Integrity – Health Insurance Premium Payment (HIPP) program

Persons/organizations authorized to receive the information:

Department of Health and Human Services, Bureau of Improvement & Integrity – Health Insurance Premium Payment (HIPP) program

Specific description of information that may be used/disclosed:

The information I authorize for release is all insurance company premium information and claim information including:

- All amounts paid by insurance company;
- All amounts denied by insurance company;
- All amounts reimbursed to any individual or agency;
- The dates of service;
- The service provided.

The information will be used/disclosed for the following purposes:

The purpose of the release of this information is for the HIPP program staff to determine eligibility for the HIPP program.

I understand that this authorization is voluntary and that I may refuse to sign this authorization. I hereby release the Department from all legal responsibility of liability that may arise from the release of these records in accordance with the NH DHHS policies. I understand that this information is necessary for an eligibility determination for the HIPP program under NH Medicaid Title XIX. I understand that I may revoke this authorization at any time by notifying the Department in writing. However, the revocation will not be valid if:

a. The Department has taken action in reliance on this authorization; or
b. If this authorization is obtained as a condition for obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Subscriber Name:

_____

Subscriber Address:

Member Names:

_____

_____

_____

_____

Please sign below.

_____ _____

Subscriber Signature Date

_____ _____

Witness Signature Date