

Lori A. Weaver Commissioner

Meredith J. Telus Director

STATE OF NEW HAMPSHIRE

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DIVISION OF PROGRAM QUALITY AND INTEGRITY

BUREAU OF PROGRAM INTEGRITY - THIRD PARTY LIABILITY UNIT

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;
- <u>Health insurance premium rate sheet from your employer that includes</u> rates/costs for all levels of plans offered (Employee Only, Employee and Spouse, Employee and Child, Family, etc.) regardless of which option you chose
- <u>Health Insurance Summary of Benefits for the current benefit year</u> (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)
- <u>If your share of the premium is payroll deducted, please provide four of your recent pay stubs</u>. Otherwise, please provide a copy of three of the most recent insurance premium invoices; (this can be sent electronically, if necessary)
- <u>Signed "Authorization to Release Protected Health Information" form.</u> 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 TPLUnit@dhhs.state.nh.us

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 ME	MBEF	R INFORMATION						
	Check here if add	ditiona	l recipients are listed in th	ne Other	r Recipient Section (see Question 7 on Page 3)				
Me	ember Name			DOB	Medicaid Id				
Ad	dress								
Home Telephone					Parent's Cellphone #				
2.	Is your health insura	nce co	verage court-ordered (part o	of a divorc	ce/separation decree)?				
3.	POLICY TYPE		Individual Non-Group		Group/Employer				
			COBRA		Health Insurance Exchange (Marketplace)				
	If you checked any l	box oth	er than <i>Group/employer</i> , plo	ease STO	OP application. You do not qualify for HIPP.				
4.	SUBSCRIBER II complete this section		MATION: If you are cur	rrently em	nrolled in health insurance through your employer, please				
Sul	bscriber Name				Relationship				
Social Security #			Date Of Birth						
Ad	dress								
Email Address			Work Number						
Home Phone					Cell Phone				
5.	EMPLOYER IN	FORM	IATION						
En	nployer Name:								
Ad	ldress:								

End Date:

Open Enrollment Period: Start Date: _____

6. <u>INSURANCE INFORMATION:</u> PEmployer Sponsored Insurance (ESI).	lease complete the information below	if you are currently enrolled in your
POLICY TYPES: MEDICAL	☐ PHARMACY ☐ VISION	☐ DENTAL
☐ Medical Insurance Insurance Company	<i>7</i> :	
Address:		
Claims Telephone #	Customer Service Telephone #	
Premium Amount \$	Frequency of Premium Payment:	
Policy #	Group #	Effective Date
Name and Tel. Number of Insurance Contact F	Person (HR/Broker):	
☐ Pharmacy Insurance Insurance Compar Address:		
Claims Telephone #		
Premium Amount \$	Frequency of Premium Payment:	
Policy #		Effective Date
Name and Tel. Number of Insurance Contact F		
☐ Vision Insurance Insurance Company		
Address:Claims Telephone #		
Premium Amount \$		Effective Date
Policy #Name and Tel. Number of Insurance Contact F		Effective Date
Dental Insurance Insurance Company (NOTE: Dental is only covered by HIE		
Address:		
Claims Telephone #	_ Customer Service Telephone #	
Premium Amount \$	Frequency of Premium Payment:	
Policy#	Group #	Effective Date
Name and Tel. Number of Insurance Contact I	Person (HR/Broker):	

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)

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)	Member (Spouse, child, etc.)	Gender	Enrolled in ESI (Employer Sponsored Insurance) (yes/no)
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		/ /				
		/ /				
			<u> </u>	<u> </u>		·

8. HEALTH SAVINGS/REIMBURSEMENT ACCOUNT

Please indicate if either of	f the following benefits we	ere offered by your	employer and if	you chose any of	them:
Health Reimburs Health Savings A	sement Account (HRA): Account (HSA):	☐ Not Offered ☐ Not Offered	Offered Offered	Chosen Chosen	☐ Not Chosen☐ Not Chosen
	ertify, under penalty of perjurerers or employers to release a ram.				
Subscriber's Signature:	Applicant/Subscriber's S	ignature	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:	Member Names:
Subscriber Address:	
Please sign below.	
Subscriber Signature	Date
Witness Signature	Date