Iowa Medicaid Enterprise-HIPP Unit
PO Box 36476
Des Moines, IA 50315-9907

Date:

HIPP Worker:
Local Calls:
Toll Free: 1-888-346-9562
Fax: (515) 725-0725
Email: HIPP@dhs.state.ia.us
HIPP ID:

Health Insurance Premium Payment (HIPP) Program Review

Dear

The Iowa Department of Human Services is reviewing your eligibility for the Health Insurance Premium Payment (HIPP) program. This program pays for the cost of health insurance premiums for Medicaid eligible members when it is determined cost-effective to do so.

Contact the HIPP worker listed above with questions or if you are having trouble obtaining the requested information. We cannot return original documents.

What you must do:

1. Complete and turn in form 470-3017, *HIPP Private Policy Review. Page 3*
2. Complete and turn in 470-2868, *HIPP Medical History Questionnaire*, for everyone in your home who gets Medicaid and is also covered by your health insurance. *Page 4*
3. Turn in items 7-9 listed on form 470-3017, *HIPP Private Policy Review. Page 3*
    - ❖ Please include the HIPP ID listed above on all documents submitted to our office.

Please keep this page as a reference. The top portion tells you how to contact your worker. The back tells you what changes need to be reported.

IMPORTANT: To ensure your HIPP payments do not stop, all of the information listed above must be received in this office by

IMPORTANT NOTICE

Please read the following information regarding your participation in the HIPP program. Questions should be referred to the HIPP worker listed on the front of this form.

Medicaid (Title 19) Eligibility

In order to be eligible for premium reimbursement through the HIPP program, some or all of the persons covered under the insurance policy must be eligible for Medicaid. If all of the persons covered under the health insurance policy lose Medicaid eligibility, HIPP premium reimbursement will stop as of the date eligibility ends. If some of the persons covered under the health insurance policy lose Medicaid eligibility, we will reevaluate the health insurance policy to see if it is still cost-effective for the Department to reimburse the premium.

Reporting Changes

You are required to report all changes to this office within 10 days of the change. Changes may impact the benefit amount and who is considered HIPP eligible. The quickest way to report changes is to:

- Call us toll-free **1-888-346-9562**
- Call the number on the front of this notice
- Email: **HIPP@dhs.state.ia.us**
- Fax: **1-515-725-0725**

You are required to report all changes that occur in your employment, health insurance, in your family, and household. Here are examples of some changes that need to be reported.

- Mailing address changes (state checks do not get forwarded).
- The health insurance ends, or the insurance carrier, premium or deductible, or coverage changes.
- The policyholder is not living with the Medicaid-eligible members.
- Medicaid-eligible member moves in or out of your home, or you are no longer responsible for their Medicaid case.
- The health insurance policy, paid by HIPP, is no longer primary for the HIPP eligible and enrolled members.
- Employment changes.

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (often referred to as COBRA), some employers must continue to make health insurance available for a limited time to persons after employment ends or hours of work are reduced (such as going from full-time to part-time). If you are eligible for insurance coverage under the COBRA provisions, your employer must give you a written notice informing you of your right to continue the coverage.

DO NOT SIGN THE FORM SAYING YOU DON'T WANT COBRA COVERAGE UNTIL WE CAN DETERMINE WHETHER THE POLICY IS COST-EFFECTIVE.

IOWA DEPARTMENT OF HUMAN SERVICES
Iowa Medicaid Enterprise-HIPP Unit
PO Box 36476
Des Moines, IA 50315-9907

Date:
HIPP Worker:
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Email: HIPP@dhs.state.ia.us

Policyholder Name:

HIPP ID:

HIPP Private Policy Review

To answer some of these questions, you may need to contact your insurance agent.

To make sure the HIPP program is paying correctly please answer questions 1-5 listed below:

1. What is your current insurance premium amount? $_____
2. What is the frequency of your premiums: ☐ Monthly (12) ☐ Quarterly (4) Other _____
3. What is your policy number? _____
4. What is the name of your insurance company? _____
5. Is this a High-Deductible Health Plan (per Internal Revenue Code Section 223(c)(2))? ☐ Yes ☐ No

To make sure the HIPP program is paying correctly please turn in the items 6-9 listed below:

6. The *HIPP Medical History Questionnaire* on the back of this form.
7. A copy of the front and back of your private health insurance card.
8. Verification of premiums paid to your insurance company (bank or credit card statement).
9. From your insurance agent or carrier:
    a. An itemized breakdown on the total health insurance premium. Proof of what the cost of coverage is for each person.
    b. Summary of Benefits and Coverage: This shows what your prescription and health insurance plan covers, including deductibles, copayments, coinsurance, and out-of-pocket costs.

IMPORTANT: To make sure your HIPP payments do not stop, all of the information listed above must be received in this office by

Over →

Remember to report if there is a change in premiums cost, deductibles, or if the health insurance ends.

Signature	**Date**
Phone Numbers	**Email address**

Iowa Department of Human Services

HIPP MEDICAL HISTORY QUESTIONNAIRE

Date:
Due Date:

To see if the HIPP program can pay for health insurance please answer the following questions regarding the health of the people who get Medicaid in your household. Check all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition.

Condition			**If yes, list the name of Medicaid-eligible member with this condition**	**How often is medical care required?**
ADHD	☐ Yes	☐ No		
Alcoholism/Drug Addiction	☐ Yes	☐ No		
Asthma or Breathing Problems	☐ Yes	☐ No		
Blood Disorder	☐ Yes	☐ No		
Cancer	☐ Yes	☐ No		
Diabetes	☐ Yes	☐ No		
Heart Condition	☐ Yes	☐ No		
HIV Positive/Acquired Immune Deficiency Syndrome (AIDS)	☐ Yes	☐ No		
Kidney or Liver Disorder	☐ Yes	☐ No		
Organ Transplant	☐ Yes	☐ No		
Pregnancy List due date:	☐ Yes	☐ No		
Scoliosis or Back Injury	☐ Yes	☐ No		
Seizure Disorder	☐ Yes	☐ No		
Stroke or Head Injury	☐ Yes	☐ No		
Other Disease/Condition Requiring Treatment (list)	☐ Yes	☐ No		
Other comments:				

Are any of the persons covered by Medicaid periodically institutionalized or currently living in an institution (mental health institution, nursing home, hospital, etc.)? ☐ Yes ☐ No
If yes, list the name of the person and the reason they are institutionalized. _____

Your Signature	Date
Email Address	
Home Phone	Other Phone

Questions or need help? Toll Free 1-888-346-9562 Des Moines area (515) 974-3282
Fax (515) 725-0725
HIPP Unit, PO Box 36476, Des Moines, IA 50315-9907