



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 _____ RIN # _____ Date: _____

Name of the person with the high cost medical condition _____

The high cost medical condition is _____

Contact information of person who maintains health insurance coverage for applicant:

Name: _____

Address _____

City: _____ State: _____ Zip: _____

SSN

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 Telephone # _____

Email Address: _____ Date of Birth: _____

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

Signature: _____ Date: _____

Authorized contact person information:

Name: _____

Address _____

City: _____ State: _____ Zip: _____

Telephone # _____ Email Address: _____

I authorize the Illinois Department of Healthcare and Family Services to obtain, as needed, any information regarding my or my family's health condition or insurance coverage, including benefits and/or payments for medical care, which may be used in determining if HFS 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 HFS.

Signature of Applicant/Client (REQUIRED) _____ Date _____

**PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS WITH SIGNED APPLICATION
(These are needed to determine eligibility for the HIPP program)**

Front and Back of Insurance Card

Physicians statement with diagnosis/prognosis of applicant's medical condition

6 months of insurance explanation of benefits (EOB)

Insurance plan booklet

Check stub if employer provided insurance coverage or proof of payment for your individual insurance

HIPP Program Contact Information

Healthcare and Family Services/HIPP Unit

P.O. Box 19149 Springfield, IL 62794-9849

E-Mail Address: HFS.BOC.HIPP@illinois.gov

Phone: 217-524-8268

FAX: 217-524-3047

Print Form