State of Illinois
Department of Healthcare and Family Services

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 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:

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

_____ _____

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

☐ an individual policy

_____ _____

Name and address of Insurance Agent Telephone #

_____ _____

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 HFS to determine if they will pay your premiums.)

- insurance plan booklet or policy
- 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 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

Print Form