NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Insurance Verification Form

HIPP Program: P.O. Box 95026 Lincoln, NE 68509-5026
Contact: 402-471-1648 or 402-471-8418 DHHS.MedicaidHIPP@nebraska.gov

The Health Insurance Premium Payment (HIPP) program is a cost savings measure for the State of Nebraska. Any information provided will remain confidential. In order to make a determination, please complete and return this form. The policyholder has authorized the release of information, through the noted signature below, for all required information. If you have questions regarding completion of the form, please contact the HIPP program by the contact information listed above.

Section 1: Release of Information (to be completed by the Employee)

By signing, I authorize the release of insurance information (including all covered individuals) to the HIPP program.
1A. Employee Name: ____________________________ 1B. Phone Number: ______________________________
1C. Address: ____
1D. Signature: ____ 1E. Date: ______________________________

Sections 2 through 5: Completed by the Employer/Self-Insured

Section 2: Employee Information *Check appropriate box*

2A. Employer/Business Contribution to the Health Insurance Premiums ☐ Yes ☐ No
2B. Employment Status ☐ Full-Time ☐ Part-Time ☐ Laid-Off ☐ Retired ☐ Former
2C. Eligible for Coverage under your Company's Health Plan ☐ Yes ☐ No
If yes, Effective date: ______________ If "no", Reason: ____
2D. Currently Enrolled in the Health Plan ☐ Yes ☐ No **If "Yes," effective date**: ______________________________
2E. Wellness Credit ☐ Yes ☐ No If so, how much and frequency _____________
2F. Any other credits, refunds, contribution, or adjustments ☐ Yes ☐ No **If "Yes," how much and frequency**:
____

Section 3: Enrolled In Health Insurance Starting with Employee/Policyholder

(Attach an additional page if more than 7)

*Name (Last, First, MI)	*Relationship to employee/Policyholder	Currently Enrolled in Health Plan
	Employee/Policyholder	☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No
		☐ Yes ☐ No

Section 4: Plan Benefits Covered

4A. Insurance Coverage Type *Check appropriate box for the employee.*
☐ Employee only ☐ Employee + Child (ren) ☐ Employee + Spouse ☐ Family ☐ Other __________

4B. Health Insurance Carrier:

Company: ________________________________ Address: ____
Phone: (___)__________ Policy Number: _______________________ Group Number:___________________

4C: Health Insurance Premium Information (exclude dental, vision, life, etc.) **Complete the selected coverage level/tier the employee/Policyholder is currently enrolled in.** Provide the employer/business and employee/policyholder contributions to the annual premium: Select one:

Coverage Level / Tier:	Health Premiums:
Employee/Policyholder Only Cost to Employer/Business Cost to Employee	$_________________________Annually $_________________________Annually
Employee/Policyholder + Spouse Cost to Employer//Business Cost to Employee	$_________________________Annually $_________________________Annually
Employee/Policyholder + Child (ren) Cost to Employer//Business Cost to Employee	$_________________________Annually $_________________________Annually
Employee/Policyholder + Family Cost to Employer//Business Cost to Employee	$_________________________Annually $_________________________Annually
Other:	$_________________________Annually $_________________________Annually

4D. Frequency of Premium Payment Deductions for Elected Insurance Plan

Weekly:	Semi / Bi-Monthly:	Monthly:
☐ 52 Weeks	☐ 24 Weeks	☐ 6 Months
☐ 50 Weeks	☐ 26 Weeks	☐ 12 Months
☐ 48 Weeks	☐ Other explain:	

Section 5: Employer/Business Representative

5A.HR Representative or Benefits Manager Name:	5B.Department:
5C.Employer / Company Name:	5D.Work Phone ( ) - EXT
5E.Employer / Company Address:	City:
State:	Zip Code:
I certify all information contained here is true and accurate to the best of my knowledge 5G. Representative's Signature: Date:	

Please return insurance verification form with insurance rate sheet and Summary of Benefits to:

By mail:
DHHS-HIPP
Medicaid and Long-Term Care
PO Box 95026
Lincoln NE 68509-9966

By email:
DHHS.MedicaidHIPP@nebraska.gov

By fax: (Attention HIPP)
402-328-6215

If you need more information, please call Annette Grefe 402-471-1648 or Dalia Glenn 402-471-8418

Insurance Verification Instructions

Section 1: Release of Information (to be completed by the Employee)
1A. Full name of the employee purchasing the health insurance.
1B. Enter the preferred contact phone number.
1C. Enter the full address.
1D. Signature authorizing the release of information for verification.
1E. Signature date.

Sections 2 through 5: Complete by the Employer

Section 2: Employee Information
2A. Check appropriate box. If yes, complete form.
2B. Check appropriate box.
2C. Check appropriate box. If yes, enter effective date of eligibility, e.g open enrollment, qualifying even,
If no, please list the reason, e.g., temporary - not eligible, eligible after waiting period, given a credit to purchase their own insurance.
2D. Check appropriate box. If yes, please list the effective date
2E. Check appropriate box if yes, amount of the credit and the frequency
2F. Any credit given by the employer or business and frequency

Section 3: Enrolled In Health Insurance (Starting with Employee/Policyholder)
List the individuals starting with the employee/policyholder covered or eligible for coverage under the health insurance including relationship to employee/policyholder. Check either currently enrolled or eligible to enroll in the health plan.

Section 4C Plan Benefits Covered: Health insurance information
4A. Check appropriate box.
4B. Insurance company name, billing address, phone number, policy number, and group number.
4C. Complete for the coverage selected. Provide the employer/business and employee/policyholder contributions to the annual premium.

Section 4D Frequency of Premium Payment
4D. Check appropriate box for frequency of deductions the employee pays for health insurance annually.

Section 5: Employer/Business Representative Information
5A. List Individual who is completing Sections 2-5 of this form.
5B. List the department represented.
5C. List employer or company name.
5D. List the preferred contact number.
5E. List the full address.
5G. Representative Signature and date.

This form is not considered complete if not received with the requested attachments.