NEBRASKA
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DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

Health Insurance Premium Payment (HIPP) Program Application / Redetermination

Check one: ☐ **Initial Application** ☐ **Redetermination**

The Health Insurance Premium Payment (HIPP) program is a cost savings measure for the State of Nebraska. The HIPP program reimburses for major medical health insurance for Nebraska Medicaid eligible clients when deemed cost-effective. HIPP program participation is voluntary and does not impact Medicaid eligibility. Participation can be voluntarily terminated by notifying the HIPP program. To be considered for HIPP participation, complete and submit this application / redetermination form. All documentation must be received within 30 days of the application/ redetermination signature date.

The following categories are excluded from HIPP for the policyholder or Medicaid eligible person (Check all that apply):

☐ Health Insurance is Court Ordered ☐ Eligible for Medicare, TriCare, CHAMPUS, CHAMPVA

☐ Premiums are fully reimbursed by the employer, a subsidy, or another third party

☐ Insurance provides only catastrophic, limited benefit, limited duration, or indemnity coverage

If any of the above boxes are checked, you are not qualified to apply for the HIPP program. Please do not complete this application / redetermination. You will not be considered for the HIPP program.

Note: Policies must be cost-effective, non-duplicative, and add coverage. If duplicative, then only the most cost-effective policy will be approved for reimbursement.

Any Medicaid-eligible client who has an existing, ongoing, and medically-confirmed medical condition determined by Medicaid to be considered a cost-effective condition is deemed to meet the cost-effective criteria. To be considered under this qualification, list diagnosis: _____.

Section 1: Medicaid Client / Policyholder Information **required field*

1A*Medicaid Client Name	1B*Client's Date of Birth		1C*Client's Medicaid Number	
1D*Medicaid Client Address		*City	*State	*Zip Code
1E*Policyholder Name	1F*Address	*City	*State	*Zip Code
1G*Policyholder SSN	1H*Phone Number		1I Email	

Section 2: Insurance Information

2A*Insurance Company	2B*Insurance Policy Number	2C*Group Number
2D*Number of Premiums per year (e.g.12,24,26,52)	2E*Premium payment amount	2F*Coverage Period

2G. Medicaid Recipients Covered by Health Insurance (Starting with Employee). Attach an additional page if more than 5. Please list all Medicaid recipients covered by insurance policy listed above. Circle the relationship to policyholder.

*Name (Last, First, MI)	*Relationship to Policyholder 1- Spouse; 2- Parent / Step-Parent; 3- Child; 4 – Step Child; 5 – Guardian; Other (specify)
	Policyholder
	1 2 3 4 5
	1 2 3 4 5
	1 2 3 4 5
	1 2 3 4 5

Section 4: Additional Documentation

3A. Does your employer contribute to the health insurance premiums: ☐ Yes ☐ No

3B. Are there any other sources that contribute to the health insurance premiums, be specific; (e.g. military, family, subsidy, etc.) _____.

The following must be submitted for consideration for HIPP participation within 30 days of the signature below:

☐ Completed and signed Application / Redetermination Form.

☐ A copy of the health insurance card (front and back).

☐ A copy of the most recent 30 days of paystubs reflecting the health insurance deduction. If self-paid, a copy of the detailed bill showing separate premiums, funds, fees and the premium covered period and proof of payment (copy of front and back of cancelled check, bank or credit card statements with the financial institution and insurance company names.)

☐ A copy of the health insurer's Summary of Benefits, in its entirety, to verify covered & excluded services.

☐ Completed Insurance Verification form with rate sheet, if employer sponsored insurance.

Please return all required documentation 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

By signing this application, I acknowledge that the information provided is accurate to the best of my knowledge and I know that my participation in the HIPP program could be affected if the information provided is inaccurate. I authorize insurers and employers to release any information necessary to determine participation for the HIPP program. I understand that I must notify the HIPP program of any changes within ten (10) days and that a denial of participation for the HIPP program is not an appealable action.

*Signature of Policyholder: _____ Date: _____

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

Section 1: Medicaid Client / Policyholder Information
1A- 1D. Enter the information for the Medicaid client.
1E – 1I. Enter the policyholder information.

Section 2: Insurance Information
2A. Enter the name of the insurance company; e.g., United Health Care, Blue Cross Blue Shield of NE, etc.
2B. Enter the policy number listed on the front of the insurance card.
2C. Enter the company's group number listed on the front of your insurance card.
2D. Circle or print the number of times insurance premiums are paid per year, e.g., State of NE has 26 pay periods but only 24 deductions in a year. If you work for the State of NE you would circle 24.
2E. Enter the amount of each premium payment.
2F. Enter the coverage period for the premium. Most coverage periods are January through December. Check with your insurance company or employer if unsure.
2G. List all Medicaid recipients covered by the insurance policy, starting with the policyholder. List name, Social Security Number, Medicaid Number (if applicable), and circle the relationship to the policyholder.

Section 3: Additional Documentation
3A. Check appropriate box. If yes, complete the Insurance Verification form.
3B. List all other sources that contribute to the payment of premiums for insurance. For example, but not limited to: a family member provides $100 to help pay the insurance premium, employer provides $500 toward the insurance premium as a credit or bonus, a premium holiday for insurance deductions, another program reimburses a portion of the premiums. List all that apply.

Provide all required documentation for consideration for HIPP within 30 days of the signing of this form.

Although not required to determine eligibility, the following will be requested:

- The State of Nebraska Substitute W-9 & ACH Enrollment Form;

HIPP program staff may reject any documentation as verification, at their discretion. Additional documentation not listed here may be required when necessary to make a determination of HIPP participation.