GEORGIA DEPARTMENT OF COMMUNITY HEALTH

HMS/HIPP UNIT – 100 Crescent Centre Parkway, Suite 1000, Tucker, GA 30084 Tel: (678) 564-1162, Option 1
Fax: (800) 817-1769 Email: hippga@hms.com

APPLICATION FOR HEALTH INSURANCE PREMIUM PAYMENT (HIPP) PROGRAM

Head of Household:	Referral Source:
Address:	Address:
City: State:	City: State:
Zip: Telephone #:	Zip: Telephone #:

1. Complete the following information regarding your health insurance policy.
Policyholder's Name:_____ Insurance Co. Name: _____
Policy Number:_____ Insurance Co. Address:_____
Group Number: _____ City/State/Zip:_____
Policyholder's Social Security Number:_____ Telephone #: _____
Policyholder's Date of Birth: _____ Policyholder's Email:_____

2. Is the policy referenced in #1 the primary policy? **YES____** **NO_____**

3. Is there a secondary policy with another employer? **YES____** **NO_____**
(If yes, please provide the information for the secondary policy on a separate page)

4. Complete the following information regarding the employer offering the policy referenced in #1.
Employer Name: _____ Employer Address:_____
Employer Telephone:_____ City/State/Zip:_____

5. List all Medicaid eligible persons covered under this policy (use back of application for additional space).

NAME:	SSN	BIRTHDATE	MEDICAID ID #	RELATIONSHIP TO POLICYHOLDER	MALE/ FEMALE
1.		/ /			
2.		/ /			
3.		/ /			
4.		/ /			
5.		/ /			

6. Are any of these persons pregnant? **Yes_____** **NO_____**
If yes:
Name **Expected Date of Delivery** **Name** **Expected Date of Delivery**

_____/____/____ _____/____/____

7. Have any of the persons in #5 been diagnosed with a medical condition? If yes, please list all medical conditions or diagnosis (please provide a separate page if additional space is needed).

Name **Condition**
YES _____ **NO** _____

8. If known, how much are the premiums for this policy? $_____

9. How often is the premium amount paid?

□ WEEKLY □ BIWEEKLY □ SEMIMONTHLY □ MONTHLY □ QUARTERLY □ OTHER

10. Complete the following information if COBRA benefits may be available from a former employer:
Have you received COBRA forms? **YES** ____ **NO**____ Date COBRA forms received _____/_____/_____
Last Date of Employment _____/_____/_____ **(Please attach copy of COBRA enrollment packet to this application)**

11. Can we contact your employer and/or insurance carrier to verify this information? YES_____ NO_____

12. Was applicant or any dependent injured at work or in an accident in the last 12 months? YES____ NO____ If yes,
Attorney Name, if applicable: **Insurance Company, if applicable:**

13. Please sign and date this application (TO BE SIGNED BY POLICYHOLDER ONLY).

Policyholder's Signature **Date**