Georgia Department of Community Health

Application For GA Health Insurance Premium Payment (HIPP) Program

Head of Household:		Referral Source:	
Address:		Address:	
City:	State:	City:	State:
ZIP:	Tel#:	ZIP:	Tel#:

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 SSN:	Telephone number:
Policyholder's date of birth:	Policyholder's email address:

2. Complete the following information regarding the employer offering this policy.

Employer name:	Employer address:
Employer telephone number:	City/State/ZIP:

3. List all Medicaid eligible persons covered under this policy (Use separate sheet of paper if needed).

Name	SSN	Birth Date	Medicaid ID Number	Relationship to Policyholder	Male/ Female
1.		/ /			
2.		/ /			
3.		/ /			

4. Are any of these persons pregnant? YES ☐ NO ☐ If yes, please provide their name and expected delivery date.

Name	Expected Delivery	Name	Expected Delivery

5. Have any of the persons in #3 above been diagnosed with a medical condition? YES ☐ NO ☐

If yes, please list all medical conditions or diagnoses. (Use a separate sheet of paper if needed.)

Name	Condition

6. If known, how much are the premiums for this policy? $ _____ These premiums are paid/deducted:

Paid/Deducted:	☐ Weekly	☐ Bi-weekly	☐ Semi-monthly	☐ Monthly	☐ Quarterly	☐ Other

7. If known, please provide the amount your employer pays for this policy. $ _____

8. If known, check the services covered under this policy.

☐ Hospital	☐ Physician	☐ Dental	☐ Drug	☐ Home Health	☐ Long Term Care

9. If known, please provide the month of your employer's open enrollment period: _____

10. Complete the following information if COBRA benefits might 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, please provide the following information:

Attorney Name, if applicable:	Insurance Company, if applicable:

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

_____ _____

Signature of applicant Date

Fax completed application toll-free to 1.800.817.1769, E-Fax to hippga@hms.com, or mail to:
GA HIPP Unit, 900 Circle 75 Parkway, Suite 650, Atlanta, Georgia 30339. Questions? Call 678.564.1162.