

Iowa Medicaid Enterprise-HIPP Unit  
PO Box 36476  
Des Moines, IA 50315-9907

Date:

HIPP Worker:  
Local Calls:  
Toll Free: 1-888-346-9562  
Fax: (515) 725-0725  
Email: HIPP@dhs.state.ia.us

## Health Insurance Premium Payment (HIPP) Program Review

Dear

It is time for the Iowa Department of Human Services to complete a review of your eligibility for the HIPP program. Complete and return items 1-3 listed below. Please fax, email, or mail the information listed below. We cannot return original documents.

What you must do:

1. Sign, date, and provide your phone number on the section labeled *Permission to Release Information* on form 470-3016, *Employer Verification for HIPP*, and then give the signed review form to your employer to complete.
2. Complete form 470-2868, *Medical History Questionnaire*, for everyone in your home who gets Medicaid and is also covered by your health insurance.
3. Send in a copy of:
  - Your most recent paystub that shows a health insurance deduction.
  - A copy of the front and back of your health insurance cards (not Medicaid cards).
  - Summary of Benefits and Coverage: This shows what your prescription and health insurance plan covers, including deductibles, copayments, coinsurance, and out-of-pocket costs.\*
  - Employer Rate Sheet: This shows the employee's cost for health insurance, including all available options to the household.\*

\* You may need to access your employer's website or contact your human resource department to get this information.

**IMPORTANT: To make sure your HIPP payments do not stop, all of the information listed above must be received in this office by**



## Employer Verification for HIPP

IOWA DEPARTMENT OF HUMAN SERVICES Iowa Medicaid Enterprise-HIPP Unit PO Box 36476 Des Moines, IA 50315-9907	Date: HIPP Worker: Local Calls: Toll Free: 1-888-346-9562 Fax: (515) 725-0725 E-mail: HIPP@dhs.state.ia.us
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### Permission to Release Information

My employer has my permission to give information about my health insurance benefits to the staff of the Iowa Department of Human Services. This information may be discussed either verbally or in writing. This permission will end thirteen months from the date of my signature. I understand that I have the right to notify my employer if I want the permission to end at an earlier date.

Name of Employee:	Phone Number:
Signature of Employee:	Date:

Give this form to your employer's human resource department to complete.

### Directions for completing this form.

Name of Employer:  
Please return by:

The Health Insurance Premium Payment (HIPP) program is reviewing eligibility for

Please call if you have any questions or need help completing this review form. When you are done, give the completed review form back to your employee or let them know if you send it to us directly. Thank you!

- The people covered under the employer sponsored health insurance are listed below. Mark yes if the person is covered by the health insurance or no if not covered by the health insurance. If someone is not listed that does have coverage, provide the individual's full name and the effective date of coverage on the back of this form in the comments section.

	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

The amount the HIPP program reimburses for your employee or to your company is not necessarily the amount the employee has deducted from their paycheck. For example, the HIPP program may only reimburse for an employee + child(ren) plan even though the employee may pay for a family plan. If your employee is enrolled in a family plan and we are reimbursing at the employee + child(ren) rates, provide both rates so we can match the rates back to the paystub.

The employer representative is to complete this form.

HIPP is reimbursing \_\_\_\_\_ . This may not match what the employee is enrolled in.

2. \_\_\_\_\_ rate:  Correct  Not Correct

3. If this is an HRA plan, how much does your employer fund annually? \$ \_\_\_\_\_

4. Health Insurance Deductible: Single \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

5. Prescription Deductible: Single \$ \_\_\_\_\_ Family \$ \_\_\_\_\_

6. Health Insurance Carrier: \_\_\_\_\_  Correct  Not Correct

7. Are there any wellness or health credits, spousal surcharges, or different rates for smoker or non-smoker? If so, please include an explanation of how much they are worth and how they are used.

8. Frequency of payroll deduction for insurance: \_\_\_\_\_  Correct  Not Correct

9. Circle the day of the week the employee gets paid: M T W Th F Sa Su

10. Are there any changes planned for the health insurance? For example, carrier change, increase in deductibles, etc.  Yes  No If yes, explain.

Comments:

Employer Representative Name (print)

Signature of Employer Representative

Date

Phone number

Fax Number

Email address



Iowa Department of Human Services

## HIPP MEDICAL HISTORY QUESTIONNAIRE

Date:

Due Date:

To see if the HIPP program can pay for health insurance please answer the following questions regarding the health of the people who get Medicaid in your household. Check all conditions that apply. If yes is checked, list the name of the person with this condition and how often medical care is needed to treat the condition.

Condition			If yes, list the name of Medicaid-eligible member with this condition	How often is medical care required?
ADHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Alcoholism/Drug Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Asthma or Breathing Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Blood Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
HIV Positive/Acquired Immune Deficiency Syndrome (AIDS)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Kidney or Liver Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Organ Transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other Disease/Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
List due date:				
Scoliosis or Back Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Seizure Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Stroke or Head Injury	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other Disease/Condition Requiring Treatment (list)	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Other comments:				

Are any of the persons covered by Medicaid periodically institutionalized or currently living in an institution (mental health institution, nursing home, hospital, etc.)?  Yes  No

If yes, list the name of the person and the reason they are institutionalized. \_\_\_\_\_

Your Signature	Date
Email Address	
Home Phone	Other Phone

**Questions or need help?** Toll Free 1-888-346-9562 Des Moines area (515) 974-3282

Fax (515) 725-0725

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