

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

HIPP Private Policy Review

Dear

The Iowa Department of Human Services is reviewing your eligibility for the Health Insurance Premium Payment (HIPP) program. This program pays for the cost of health insurance premiums for Medicaid eligibles when it is determined cost-effective to do so.

To make sure the HIPP program is paying correctly please answer questions 1-4 listed below:

1. What is your current insurance premium amount? \$ _____
2. Circle the frequency of your premiums: Monthly, Quarterly, Semi-Annually, Annually,
Other _____
3. What is your policy number? _____
4. What is the name of your insurance company? _____

To make sure the HIPP program is paying correctly please turn in the items 5-8 listed below:

5. The HIPP Medical History Questionnaire on the back of this letter.
6. A copy of your private health insurance card.
7. Verification of premiums paid to your insurance company (bank or credit card statement).
8. From your insurance agent or carrier:
 - a. An itemized breakdown on the total health insurance premium. Proof of what the cost of coverage is for each person.
 - b. Summary of Benefits and Coverage: This shows what your prescription and health insurance plan covers, including deductibles, copayments, coinsurance, and out-of-pocket costs.

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

Over →

Remember to report if there is a change in premiums cost, deductibles, or if the health insurance ends.

Signature	Date
Phone Numbers	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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