



HEALTH INSURANCE PREMIUM PAYMENT (HIPP) REFERRAL

**IF YOU HAVE A HIGH COST MEDICAL CONDITION AND GROUP HEALTH INSURANCE AVAILABLE TO YOU
YOU ARE REQUIRED TO COMPLETE THIS FORM TO BE ELIGIBLE FOR MEDICAL ASSISTANCE**

Case Name _____ Case # _____ Date: _____

1. Name of the person with the high cost medical condition _____

The high cost medical condition is _____

2. Name of person who has (or can) enroll in the health plan _____

Address _____

SSN _____ Telephone # _____

3. If the person listed in #2 above is not requesting or receiving medical assistance and would be agreeable to enroll the person listed in #1, check here

If possible, ask the person listed in #2 to sign and date the authorization below:

I authorize HFS to obtain, as needed, any information regarding my health insurance coverage which may be used to determine if HFS will pay part or all of my insurance premium.

Signature: _____ Date: _____

4. Is available health insurance a group through (check one) current employer former employer
 union or group (Local #) _____ other group

Name and address of current/former employer, union or group Telephone #

an individual policy

Name and address of Insurance Agent Telephone #

Name and address of Insurance Carrier Policy #

Is Insurance: in force, next premium is due _____

COBRA continuation insurance last day to enroll is _____

available but not applied for, next open enrollment begins _____ ends _____

6. What types of services does the health plan cover? (check all that apply)

Major Medical HMO Prescription Drugs

PLEASE ATTACH COPIES OF THE FOLLOWING DOCUMENTS YOU MAY HAVE.
(This will help HFS to determine if they will pay your premiums.)

- insurance plan booklet or policy
- explanation of benefits (EOB)

If another health plan is available to you or your family, complete a separate form for each plan.

I authorize the Illinois Department of Healthcare and Family Services to obtain, as needed, any information regarding my or my family's health condition or insurance coverage, including benefits and/or payments for medical care, which may be used in determining if HFS will pay health insurance premiums for continued coverage. If I am or a member of my family is determined to be eligible to participate in HIPP, I authorize health insurance premium notices to be sent directly to HFS.

Signature of Applicant/Client (REQUIRED)

Date