

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

DIVISION OF HEALTH CARE FINANCE

HEALTH INSURANCE PREMIUM PAYMENT INFORMATION FORM

Fill out this form to see if you and your family could have your health insurance premiums paid for you. To be eligible 1) at least one family member must be currently enrolled in the Kansas Medical Services program and 2) at least one member of your family, who is 18 years of age or older, must be currently employed; OR in cases where a family member has recently lost his or her job, the employee and the Medicaid eligible family member must be eligible for a COBRA insurance plan through his or her former employer. If you have questions or need help in filling out this form call 1-800-967-4660. We may need to contact you if we need more information. **Please print.**

1. PROVIDE US WITH CASE INFORMATION

Name of family member who receives Medicaid.....

Beneficiary ID of family member who receives Medicaid.....and/or Case Number.....

Street Address.....

City.....State.....Zip.....

If we need additional information, we will try to contact you by phone. Which time is the best to reach youAM or PM

Home # (.....)..... Work # (.....)..... Is it o.k. to call you at work? YES NO

2. LIST NAMES AND EMPLOYER INFORMATION FOR ALL PERSONS IN YOUR FAMILY OVER 18 YEARS OF AGE WHO ARE WORKING AND ABLE TO COVER MEDICAID ELIGIBLES ON INSURANCE

1) NAME	SOCIAL SECURITY NUMBER		
EMPLOYER NAME	EMPLOYER'S STREET ADDRESS		
EMPLOYER TELEPHONE #	CITY	STATE	ZIP
2) NAME	SOCIAL SECURITY NUMBER		
EMPLOYER NAME	EMPLOYER'S STREET ADDRESS		
EMPLOYER TELEPHONE #	CITY	STATE	ZIP
3) NAME	SOCIAL SECURITY NUMBER		
EMPLOYER NAME	EMPLOYER'S STREET ADDRESS		
EMPLOYER TELEPHONE #	CITY	STATE	ZIP

3. PLEASE TELL US THE NAME OF ANYONE IN YOUR HOUSEHOLD, ON MEDICAL ASSISTANCE, WHO HAS ANY OF THE FOLLOWING CONDITIONS

PREGNANCY _____	ORGAN TRANSPLANT _____	HIV/AIDS _____
DIABETES _____	KIDNEY/LIVER ILLNESS _____	OTHER _____
CANCER _____	HEART CONDITION _____	_____

Return this form using the postage-paid label included or send to HIPPS Unit, P.O. Box 3571, Topeka, KS 66601 or Fax to (785) 274-5918.

Important note: The information on this form is confidential and will only be used to determine if your family is eligible to have your health insurance premiums paid for you through the HIPPS program.

The HIPPS Program

The State of Kansas Health Insurance Premium Payment System (HIPPS) Program may be able to pay health insurance premiums for you and/or your family if a member of your family is employed and/or someone in the family has a serious illness with high medical bills.

What are the benefits of participating in the HIPPS Program?

- Your employer's health insurance policy may cover services that are not covered by Medicaid
- The HIPPS Program may be able to pay for the entire family, even if only one member is eligible for Kansas Medicaid Services.
- The HIPPS Program may be able to purchase a COBRA Plan for those family members on Medicaid, if the employee has recently lost his or her job and the family member(s) have high medical expenses.

How do I qualify for the HIPPS Program?

- At least one family member must be currently enrolled in the Kansas Medicaid Program
- At least one family member, who is 18 or older must be employed and able to cover Medicaid eligible person(s) on insurance through employer OR in cases where the employee has recently lost his or her job, the employee and Medicaid eligible person(s) must be eligible for COBRA insurance plan.
- You must fill out and return the Information Form printed on the back.

If you have any questions about the HIPPS Program and how it could help your family, call 1-800-967-4660.