HEALTH INSURANCE PREMIUM PAYMENT APPLICATION

(See instructions for completing on reverse)

1. Name of applicant/Medi-Cal beneficiary	2. Social Security number	3. Telephone number ( )

4. Beneficiary's address	City	State	ZIP code

5. Name of insurance carrier	6. Insurance carrier's telephone number ( )

7. Premium billing location (where premiums are mailed)	City	State	ZIP code

8. Policy number	9. Current premium amount $	10. How often is it paid (check which applies) ☐ Monthly ☐ Quarterly ☐ Other:

11. Current policy status (check and fill in date, if applicable)

COBRA ☐ Yes ☐ No ☐ Policy is paid through: ☐ Policy lapsed on:

12. Type of coverage your insurance provides (check all that apply)

☐ Hospital stays
☐ Hospital outpatient (i.e., lab work or physical therapy)
☐ Doctor visits
☐ Prescription drugs
☐ Vision care
☐ Dental care
☐ Long Term Care (LTC)
☐ Medicare supplement policy

13. Name of policyholder	14. Policyholder's Social Security number

15. Policyholder's address	City	State	ZIP code	16. Policyholder's telephone number ( )

17. Is the policyholder court ordered to provide the medical insurance? ☐ Yes ☐ No	18. Is the policy a Medicare Supplement? ☐ Yes ☐ No

19. How are the insurance premiums currently paid (check which applies)

☐ Paid ENTIRELY by employer
☐ Paid by policyholder directly to insurance carrier
☐ Paid by policyholder through payroll deduction
☐ Paid ENTIRELY by an absent parent
☐ Other:

20. Name and Social Security Number of other family members covered by Medi-Cal *AND* the private insurance listed in item 5:

Name	**Social Security Number**

21. Policyholder's employer	22. Employer's telephone number ( )

23. Employer's address	City	State	ZIP code

24. Does anyone listed on this application have a high-cost medical condition that requires a physician's treatment? If so, list the name and type of illness (use additional paper if necessary).

Name	Illness	Name	Illness

IMPORTANT: As a condition of eligibility, all Medi-Cal beneficiaries shall assign rights to medical insurance, support, or other third-party payments to the Medi-Cal program and shall cooperate with the California Department of Health Care Services in obtaining medical support or payments. The assignment of rights to benefits is effective only for services paid for by the Medi-Cal program. Assignment of medical rights allows the California Department of Health Care Services to recover funds from health insurance companies or funds when the Medi-Cal program pays for medical services, which should have been billed to other health insurance coverage. Please note that in order to comply with the Federal Privacy Act (42USC, Section 552a) your Social Security Number and any information you provide may be used to contact insurance companies, employers, providers of health care services, and county agencies to determine the extent of available health insurance. Under Welfare and Institutions Code, Section 14100.2, any submitted information is considered confidential and disclosed only as necessary for Medi-Cal program administration purposes.

AUTHORIZATION: "I hereby authorize the California Department of Health Care Services to obtain, if needed, any information regarding my private health insurance coverage, including payments and/or benefits for medical care made in my behalf, which may be used in determining if the California Department of Health Care Services will pay health insurance premiums for continued coverage."

25. Signature of Medi-Cal Beneficiary	Date

INSTRUCTIONS FOR COMPLETING THE HEALTH INSURANCE PREMIUM PAYMENTAPPLICATION FORM DHCS 6172

The following instructions are to be used in completing the Health Insurance Premium Payment application. PLEASE PRINT THE INFORMATION.

1. Enter your full name.
2. Enter your nine-digit Social Security number.
3. Enter your complete daytime telephone number, including area code. If you do not have a telephone number, please enter a message telephone number in the telephone number box and indicate, “message.”
4. Enter your complete street address, city, state, and zip code.
5. Enter the name of your current health insurance carrier.
6. Enter the telephone number, including area code, of your health insurance carrier.
7. Enter the complete street address, city, state, and zip code where your premiums are mailed.
8. Enter your health insurance policy number.
9. Enter your current health insurance premium amount.
10. Indicate how often you pay your health insurance premiums by checking the appropriate box.
11. Indicate if your health insurance is being paid through COBRA by checking the yes or no box. Also, indicate the date your policy is paid through. If your policy has lapsed within the last 90 days, indicate the date the policy lapsed.
12. Indicate, by entering a checkmark in the appropriate box(es), the medical services that are covered by your health insurance policy.
13. Enter the full name of the insured/policyholder. This is the name of the person to whom the policy was issued.
14. Enter the nine-digit Social Security number of the policyholder.
15. Enter the complete street address, city, state, and zip code of the policyholder.
16. Enter the policyholder’s daytime telephone number, including area code. If the policyholder does not have a telephone number, please enter a message telephone number in the telephone number box and indicate “message.”
17. Indicate if the policyholder is court ordered to provide the insurance for the applicant.
18. Indicate if the policy is a Medicare HMO policy.
19. Indicate, by entering a checkmark in the appropriate box, how the insurance premiums are currently paid.
20. Enter the complete name and nine-digit Social Security number of other family members that are covered by Medi-Cal *AND* the health insurance policy listed in item 5.
21. Enter the full name of the policyholder’s employer.
22. Enter the telephone number of the policyholder’s employer, including area code.
23. Enter the full street address, city, state, and zip code of the policyholder’s employer.
24. Enter the name and type of illness for persons listed in item 18 who have a high-cost medical condition.
25. Sign and enter the date when you have completed this form.

Mail this form to: Department of Health Care Services, HIPP Program, MS 4719, PO Box 997422, Sacramento, CA 95899-7422. If you have any questions about completing this form, call toll free 1-866-298-8443 (California only), 8:00 a.m.–5:00 p.m., Monday through Friday.