Health Insurance Premium Payment (HIPP) Program

# RELEASE OF INFORMATION

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| **INSURANCE COMPANY NAME:** | |
| **INSURANCE COMPANY ADDRESS *(street, city, state, zip code)*:** | |
| **NAME OF POLICYHOLDER: *(last, first, middle)*:** | |
| **POLICYHOLDER MEDICAL RECORD NUMBER:** | |
| **HIPP CASE ID NUMBER:** | **DATE:** |

Attention Claims/Billing Office:

I, _____ (policyholder), hereby authorize the California Department of Health Care Services (DHCS) to obtain, if needed, any information regarding my private health insurance coverage. This information may include payments, account status or benefits for medical care made on my behalf. This information may be used in determining if DHCS will continue to pay health insurance premiums for coverage under the provisions of the Health Insurance Premium Payment (HIPP) Program.

I also authorize the above-named insurance company to reimburse the DHCS HIPP Program for any overpayments of premiums paid to the insurance company by HIPP as a result of my participation in the HIPP Program. If I receive any reimbursement from the above-named insurance company, I acknowledge that I must repay the HIPP Program the full amount of said reimbursement within thirty (30) days.

Signed: _____ Date: _____

Under the provisions of the California Welfare and Institutions Code Section 14100.2, any information gathered is considered confidential and disclosed only as necessary for the Medi-Cal program administration purposes. Under the provisions of the Federal Privacy Act, this authorization may be revoked. Information disclosed may be subject to re-disclosure by DHCS and no longer protected by the Federal Privacy Act. This authorization is valid for one (1) year from the date of signature.