State of California
Health and Human Services Agency

Department of
Health Care Services

Health Insurance Premium Payment Application

(See instructions for completing on reverse)

Step 1: Tell us about who is applying to the Health Insurance Premium Payment (HIPP) Program

1. Name of Applicant	2. Social Security Number	3. Telephone Number

4. Applicant's Home Address	City	State	Zip Code

Step 2: Tell us about your Health Insurance Policy

5. Name of Insurance Carrier	6. Policy Start Date

7. Premium Billing Address (where premiums are mailed)

City	State	Zip Code

8. Policy Number	9. Total Monthly Premium	10. Total Number of People Covered under Policy

11. Name of Policyholder	12. Policyholder's Social Security Number

Step 3: HIPP Eligibility Requirements

13. Is the applicant enrolled in Medi-Cal?	Yes ☐ No ☐
14. Is the applicant enrolled in a Medi-Cal Managed Care Plan?	Yes ☐ No ☐ Unknown ☐
15. Is the policyholder court ordered to provide the medical insurance?	Yes ☐ No ☐
16. Is the applicant enrolled in Medicare?	Yes ☐ No ☐
17. Is the policyholder fully reimbursed for payment of health care premiums?	Yes ☐ No ☐
18. If in Medi-Cal, has the applicant maintained the same insurance policy since they were first enrolled in Medi-Cal?	Yes ☐ No ☐

If yes to questions 14, 15, 16, or 17, the applicant is not eligible for the HIPP program.
If no to questions 13 or 18, the applicant is not eligible for the HIPP program.

Contact DHCS at HIPP@dhcs.ca.gov or (916) 445-8322 for questions regarding eligibility requirements.

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 (42 USC, 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 on my behalf, which may be used in determining if the California Department of Health Care Services will pay health insurance premiums for continued coverage.”

19. Signature of Applicant (or Authorized Representative	Date

Instructions for completing the Health Insurance Premium Payment Application

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

1. Enter the applicant's full name.
2. Enter the applicant's nine-digit Social Security number.
3. Enter the applicant's complete daytime telephone number, including area code.
4. Enter the applicant's complete street address, city, state, and zip code.
5. Enter the name of the applicant's current health insurance carrier.
6. Enter the initial policy start date of the health insurance policy listed in items 5 and 8.
7. Enter the complete street address, city, state, and zip code where the applicant mails his/her premium payments to the insurance carrier.
8. Enter the applicant's health insurance policy number.
9. Enter the total monthly premium amount for health insurance.
10. Enter the total number of people covered by the health insurance policy listed in items 5 and 8.
11. Enter the full name of the policyholder of the health insurance policy listed in items 5 and 8. This is the name of the person to whom the policy was issued.

12. Enter the nine-digit Social Security number of the policyholder.
13. Indicate if the applicant is currently enrolled in Medi-Cal by checking the yes or no box.
14. Indicate if the applicant is currently enrolled in a Medi-Cal Managed Care Plan by checking the yes, no, or unknown box.
15. Indicate if the policyholder is court ordered to provide the insurance for the applicant by checking the yes or no box.
16. Indicate if the applicant is currently enrolled in Medicare by checking the yes or no box.
17. Indicate if the policyholder is fully reimbursed for payment of health care premiums by checking the yes or no box.
18. Indicate if the applicant has the same health insurance policy since they were first enrolled in Medi-Cal by checking the yes or no box.
19. 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 997425, Sacramento, CA 95899-7422. If you have any questions about completing this form, call (916) 445-8322, 8:00 a.m. – 5:00 p.m., Monday through Friday.