LOUISIANA DEPARTMENT OF HEALTH
Medicaid

The Louisiana Health Insurance Premium Payment Program
LaHIPP

THE LOUISIANA HEALTH INSURANCE PREMIUM PAYMENT PROGRAM

Health Insurance Information Form

- This form **MUST** be completed by the entity providing health insurance to the LaHIPP applicant, in order to make a final determination of eligibility for health insurance premium reimbursement. Although some information may not relate to the applicant or they may not currently have health insurance, this information is still needed.
- If you need extra space, use a separate sheet of paper.
- If you have any questions, call **1-877-697-6703** Monday–Friday between 8:00 AM–5:00 PM to speak with a LaHIPP representative, or visit us online at our website **http://ldh.la.gov/lahipp**.
- Complete and mail this form to **Attn: LaHIPP, 100 Crescent Centre Pkwy, Suite 1000, Tucker, GA 300084** or fax it to **1-888-716-9787**. You can also e-mail a copy of this form to **La.HIPP@la.gov**.

► *Please **PRINT** clearly in black ink.*

1 — Employer's Information	
Employer name	Employer phone number ( )
Employer address	Employer Federal Tax ID *(mandatory)*

2 — Insurance Carrier Information	
Insurance carrier name	Insurance carrier phone number ( )
Insurance carrier address	Insurance carrier fax number *(if applicable)* ( )
Are multiple plans offered by this insurance carrier? ☐ Yes ☐ No *(Please submit a summary of benefits for all plans with this form)*	
Is there an Open/Annual Enrollment Period? ☐ Yes ☐ No	If **NO**, when would changes to insurance go into effect?
If **YES**, what are the dates for this period? Begin date: End date:	When would changes to insurance go into effect for this period?

3 — Insurance Coverage Information

What coverage is provided by the insurance carrier? *(Check all that apply)*

☐ Major Medical ☐ Health Savings Account ☐ Health Reimbursement Account

☐ High Deductible — Amount: _____ ☐ Other: _____

Tell us your policyholder's share of monthly premiums. If any standard tiers are not applicable, please indicate with N/A)

Standard Tiers	Monthly Premium Share *(without wellness credit)*	Plan Deductible Amount
Policyholder Only	$	$
Policyholder and Children	$	$
Policyholder and Spouse	$	$
Family	$	$

How frequent are premiums paid?

☐ Weekly (**48** times a year) ☐ Weekly **(52** times a year) ☐ Biweekly (**24** times a year) ☐ Biweekly (**26** times a year)

☐ Monthly ☐ Semi-Monthly ☐ Annually ☐ Other: _____

4 — Applicant Information (Private Insurance)

Is the LaHIPP applicant actively receiving coverage from an employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ Yes ☐ No *(if **NO**, skip to section 5)*

Provide the following information for the policyholder.

First name | Middle initial | Last name | Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

Insurance policy number	Insurance group number

Is this an employer-sponsored insurance (ESI) or an individual health insurance (IHI) policy? ☐ ESI ☐ IHI

Is the first month's premium due before coverage becomes effective? ☐ Yes ☐ No

Can changes be made to this coverage by the policyholder at times other than open/annual enrollment? ☐ Yes ☐ No

Provide the following information for all dependants of the policyholder who are enrolled or have been enrolled in their health insurance plan. Include information for the policyholder.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

5 — Applicant Information (COBRA)

Is the LaHIPP applicant actively receiving COBRA coverage? ☐ Yes ☐ No *(if **NO**, skip to section 6)*

Provide the following information for the COBRA policyholder.

First name	Middle initial	Last name	Suffix *(Sr., Jr., etc.)*

Social Security number	Date of birth	Sex ☐ Male ☐ Female

When did COBRA coverage begin?	What was the name of their COBRA contact?

COBRA phone number ( )	COBRA fax number *(if applicable)* ( )

Provide the following information for all dependants of the COBRA policyholder who are enrolled or have been enrolled in a COBRA health insurance plan.

Name	Social Security Number	Date of Birth	Date Added to Insurance	Insurance End Date

6 — Human Resources Representative Information and Signature

Name of representative completing form		

Representative mailing address		

Representative phone number ( )	Representative fax number *(if applicable)* ( )	Representative e-mail address

Sign here:	Date:

Thank you for your time in assisting Medicaid and LaHIPP!

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