STATE OF NEVADA
Department of Health and Human Services
Division of Health Care Financing and Policy

Health Insurance Premium Payment (HIPP) Program Application

HOUSEHOLD INFORMATION

Head of the Household Name *(Last, First)*	Date of Birth	Social Security Number	Enrolled in Medicaid?
			☐ Yes ☐ No Medicaid ID:
Physical Address	**Apt./Space**	**City/State**	**Home/Cell Phone**
Marital Status ☐ Married ☐ Single ☐ Partner ☐ Divorced If married, provide name: (Last, First)	**Date of Birth: spouse/partner**	**Social Security Number**	☐ Yes ☐ No Medicaid ID:

EMPLOYER INFORMATION

Employer's Name and Address	Employer's Tax: ID #	Human Resource Contact Number	Open Enrollment Dates

HEALTH INSURANCE INFORMATION

Policy Holder Name	Social Security Number	Insurance Company Name	Group/Policy Number

Available Insurance Coverage	Premiums and Deductibles
☐ Major Medical (including hospital, outpatient, physician, etc.) ☐ Dental ☐ Vision ☐ Medicare ☐ Prescription Drugs ☐ Health Maintenance Organization (HMO) Other: _____ _____	☐ Paid by policyholder through payroll deduction ☐ Paid by policyholder to insurance carrier ☐ Paid entirely by employer ☐ Other _____ **Frequency:** ☐ Weekly ☐ Bi-weekly ☐ Monthly ☐ Quarterly ☐ Other **Amount: $_____** **Yearly Deductible:** Single $_____ Family $_____

HOUSEHOLD MEMBERS *(Currently Covered or Eligible to be Covered by Your Insurance)*

Name *(Last, First)*	Date of Birth	Relationship to Insured	Enrolled in Medicaid?	Catastrophic Health Condition?
			☐ Yes ☐ No Medicaid ID:	☐ Yes ☐ No Please specify:
			☐ Yes ☐ No Medicaid ID:	☐ Yes ☐ No Please specify:
			☐ Yes ☐ No Medicaid ID:	☐ Yes ☐ No Please specify:

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Required Documents:

- ☐ **Copy of the four (4) most recent paystubs.**
- ☐ **Copy of the front and back of commercial (Employer) health insurance card.**
- ☐ **Copy of the front and back of Medicaid card.**
- ☐ **Copies of Explanation of benefits (EOB)/ Medical bills for the last twelve (12) months for enrollee.**

Please answer all of the questions to the best of your ability and sign the application. Attached is a Health Insurance Portability and Accountability Act of 1966 (HIPAA) release form that also needs to be signed in order to verify the information contained on this application. If you have any questions or need help completing this form, please call toll free at **1 (888) 346-1380.**

The Department of Health and Human Services, Division of Health Care Financing and Policy, provides services without discrimination of any kind due to race, national origin, color, gender, religion, age or disability (including AIDS and related conditions) as required by federal law.

Fax: 1-877-640-3414
Email: customerservice@mynvhipp.com
Mail to: HMS
P.O. Box 12610
Reno, Nevada 89510

_____ _____

Signature **Date**

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HIPAA RELEASE AUTHORITY

AUTHORIZATION FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Recipient's Name: _____

Medicaid ID #: _____ **HIPP Effective Date:** _____

[This Release Authority Applies to Any Information Governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")]

1. I hereby authorize my employer's health insurance carrier or my employer's benefits representative to release or disclose my Protected Health Information (PHI) as described below. I understand that the information may be re-disclosed and no longer protected by federal privacy regulations.

2. Information obtained will be used for the following purpose(s): Prequalification for enrollment in the Health Insurance Premium Payment (HIPP) program, and re-evaluation for continued enrollment. HIPP is administered by Health Management Systems (HMS) on behalf of the State of Nevada, Division of Health Care Financing and Policy (DHCFP). Prequalification requires contact with your insurance carrier or your employer's benefits representative to verify insurance information such as policy number, coverage, premiums and co-payments.

3. Persons or entities authorized to receive and use the information include the DHCFP and its Fiscal Agent, DXC Technology and HMS. This HIPAA Authorization form is in effect until I am no longer receiving services from Medicaid.

4. No person and/or entity authorized to use/disclose the information will receive compensation for doing so.

5. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my payment for or coverage of services, or ability to obtain treatment; however, it may or may not affect my eligibility for future services as specified under number (6) of this form.

6. The purpose of this authorization is for the DHCFP to determine HIPP eligibility before enrollment; the requested use or disclosure is not for psychotherapy notes. If I refuse to sign this authorization, the DHCFP reserves the right to deny enrollment or eligibility for benefits.

7. I understand that I may revoke this authorization at any time by notifying the DHCFP in writing, except to the extent that:

   a) Action has already been taken as a result of this authorization; or
   b) If this authorization is obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

8. I understand that I may inspect or copy the information used or disclosed.

9. I understand that I have a right to request and receive a Notice of Privacy Practices from the DHCFP.

_____	_____
Signature of Recipient or Personal Representative	Date
_____	_____
Printed Name of Recipient or Personal Representative	Relationship to Recipient or Personal Representative

The HIPP program is administered by HMS., under contract with the Department of Health and Human Services, Division of Health Care Financing and Policy.