

Each month, HIPP members receive a reimbursement for the cost of their health insurance premiums.

If cost-effective to the state, HIPP will even cover the monthly cost of a family policy.



Even Medicaid families can benefit from having health insurance coverage! Health insurance may provide you with benefits, such as:

1. Health care for your entire family, even family members who are not eligible for Medicaid - if found to be cost effective
2. Specific services that are not provided to those only covered by Medicaid
3. Access to a wider network of doctors and specialists

#### To qualify for HIPP, your application must show:

1. You have one or more Medicaid dependents
2. A household member is either currently enrolled in or has access to health insurance
3. This health insurance is provided by an employer
4. This health insurance will cover a dependent that is Medicaid eligible
5. The state will save money by paying for the cost of your Medicaid dependent's health care coverage\*

\*This is determined by comparing the annual cost of your health insurance premium and the annual cost of your Medicaid dependent's medical expenses.



#### Applying for HIPP is easy.

Just complete the application on the inside of this brochure and send it in!

Toll free fax: 1-855-357-1130  
Mail: AL HIPP 3066 Zella Rd. Box 233  
Montgomery, AL 36106  
Submit an online application at:  
[www.MyALHIPP.com](http://www.MyALHIPP.com)

Do you need help filling out the AL HIPP application?  
We're here to help.

Call us toll free at 1.855.MYALHIPP (855.692.5447),  
Monday through Friday between 8am-5pm.

Did you know...  
By providing premium reimbursements to HIPP members, AL HIPP helps save state and taxpayer money. You can help these efforts by applying to the AL HIPP program today. Learn more about AL HIPP by visiting our website at [www.MyALHIPP.com](http://www.MyALHIPP.com).

# AL HIPP



HIPP is a state-funded program that offers MORE health care options to YOU and your FAMILY!

AL HIPP is sponsored by the Alabama Medicaid Agency.



#### When you become a HIPP member...

HIPP pays for your health insurance provided by your job as well as most out-of-pocket medical costs that fall under your responsibility to pay after visiting your doctor.

#### Why is it important for you to have insurance?

Insurance can help you gain better access to specialists that treat your specific needs as a patient. It also offers you an opportunity to have family coverage, at no cost to you. Read the inside of this brochure and complete and submit the attached application or apply online at [www.MyALHIPP.com](http://www.MyALHIPP.com) to see if you qualify for AL HIPP benefits.





The Alabama HIPP program is for qualifying Medicaid recipients and their families who have access to group health insurance from a job.



### Already paying for health insurance coverage?

Are you at risk of losing your coverage due to inability to pay? If found eligible, HIPP can take over this financial responsibility.

**Have you always wanted health care coverage, but could not afford the premium payments?** If found eligible, HIPP offers reimbursements to those unable to cover the cost of their health care policy.

**HIPP does not affect Medicaid eligibility. Once enrolled in AL HIPP:**

1. Medicaid recipients will continue to receive Medicaid benefits for as long as they are found eligible for Medicaid by the Alabama Medicaid Agency
2. Policyholders will receive monthly reimbursements for the cost of their group health insurance premium
3. Medicaid recipients' out-of-pocket medical costs will be paid by Medicaid if they receive treatment from a Medicaid provider



## ALABAMA HEALTH INSURANCE PREMIUM PAYMENT APPLICATION FORM

Please fill out questions 1-5 with applicant's personal information.

1. Name:	2. Social Security Number:
3. Address:	4. Area Code/ Phone Number:

5. ☐ **EMAIL** (Check box to sign up for email notifications.): Yes, once available, I choose to receive emails from HIPP that will include important information about the program and my payments. I understand that my email will not be used for anything other than HIPP correspondence. **Email Address:** \_\_\_\_\_

6. How did you hear about HIPP (choose an option below)?

<input type="checkbox"/> Mail	<input type="checkbox"/> Medicaid Caseworker	<input type="checkbox"/> Online search engine	<input type="checkbox"/> Health related support group	<input type="checkbox"/> Other: _____
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7. Policyholder's Name:	8. Policyholder's Date of Birth:
9. Policyholder's Social Security Number:	10. Policy Number:
11. Insurance Carrier Name:	12. Policy Start Date:

13. Type of policy coverage (Check One): ☐ Individual ☐ Individual + Child(ren) ☐ Individual + Spouse ☐ Family  
14. How are premiums paid (Check One)? ☐ Insured pays Insurance Carrier ☐ Insured pays Employer ☐ Payroll deduction  
15. What type of health insurance do you have access to (Check One)? ☐ Employer ☐ Cobra ☐ Private ☐ Other ☐ None  
**Employer or COBRA insurance policyholders, please continue to question 16. Private or Other policyholders, please skip down to 21.**

16. Open enrollment dates for health insurance obtained from employer? Start: \_\_\_\_/\_\_\_\_/\_\_\_\_ End: \_\_\_\_/\_\_\_\_/\_\_\_\_

17. Name of Employer:	18. Employer Telephone:	19. Employer Mailing Address:
20. Federal Employer Identification Number (FEIN):		21. Group Number

22. What is the premium for this policy (if known)? \$ \_\_\_\_\_ These premiums are deducted/ paid:

<input type="checkbox"/> Weekly	<input type="checkbox"/> Every other week	<input type="checkbox"/> Twice a month	<input type="checkbox"/> Monthly	<input type="checkbox"/> Every three months	<input type="checkbox"/> Other
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23 List everyone in your household covered by your policy, including Medicaid recipients. (Use extra paper if necessary.)

Name	Medicaid ID Number	Social Security Number	DOB	Medical Condition (Diabetes, asthma, etc)	Is this person pregnant?	Relationship to policyholder

Submitting "Medical Condition" is optional, although, listing this specific information may benefit the applicant.

24 ☐ **DIRECT DEPOSIT** (Check box to sign up for Direct Deposit): If accepted onto the HIPP program, once this option is available, I would like to participate in the Direct Deposit program. By doing so, HIPP will deposit my payments into my checking account and I will not receive a paper check. If I am not accepted onto the program, HIPP will properly discard my banking information. **Bank Name:** \_\_\_\_\_ **Routing #:** \_\_\_\_\_

**Checking Account #:** \_\_\_\_\_ (Please provide a copy of your voided check with this application.)

25. ☐ **EMPLOYER CONTACT** (Check box if you agree.): The HIPP program has permission to contact my employer to verify employer information that is necessary to process my HIPP application.

26. **APPLICANT'S AGREEMENT:** The information you provided will be used to determine your HIPP eligibility. By signing below, you are agreeing that the information provided on this form is true and complete to the best of your knowledge.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Send your completed application to AL HIPP, 3066 Zelda Rd. Box 233 Montgomery, AL 36106, or fax it to 855-357-1130.  
If you have any questions, call us toll-free phone at: 1-855-MyALHIPP.