3501 MacCorkle Ave SE #201
Charleston, WV 25304

Earl Ray Tomblin, Governor Michael J. Lewis, M.D., Ph.D., Cabinet Secretary

Dear Applicant,

The West Virginia Health Insurance Premium Payment (HIPP) program reimburses the cost of health insurance coverage for eligible policyholders and their dependents that are current Medicaid members. To apply to the WV HIPP program, fill out the attached application and either fax or mail it back to the WV HIPP program within 10 days. For faster processing, we ask that you please follow all instructions while completing your application.

Fax: 855-888-3003
Address: WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

Private policyholders: Complete FORM ONE and return it to the WV HIPP program. You may discard FORM TWO.

Employer-sponsored policyholders: Complete FORM ONE and FORM TWO and return it to the WV HIPP program. FORM TWO should be completed by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

If you have any questions, please contact the WV HIPP program at our toll-free phone number 1-855-MyWVHIPP (855-699-8447) or visit us online at www.MyWVHIPP.com.

Sincerely,

The HIPP Team

3501 MacCorkle Ave SE #201
Charleston, WV 25304

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FORM ONE: West Virginia Health Insurance Premium Payment Application

Private policyholders: Complete FORM ONE and return it to the WV HIPP program. You may discard FORM TWO.

Employer-sponsored policyholders: Complete FORM ONE and FORM TWO and return it to the WV HIPP program. FORM TWO should be completed by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

1. Do you or anyone in your family receive Medicaid Benefits? ❑ YES ❑ NO

2. Do you or anyone in your family have health insurance? ❑ YES ❑ NO

3a. **IF YES,** which type: ❑ EMPLOYER ❑ COBRA ❑ OTHER

3ai. What is the premium for this policy (if known)? $_____These premiums are paid/ deducted:

❑ Weekly	❑ Every other	❑ Twice a month	❑ Monthly	❑ Quarterly	❑ Other

3aii. Type of Coverage: ❑ Individual ❑ Individual and child ❑ Individual and Spouse ❑ Family

3b. **IF NO,** do you have access to health insurance, such as insurance benefits through your job? ❑ YES ❑ NO

Tell us as much as you can about the health insurance plan that you have access to. **If you do not have access to health insurance, you do not qualify for WV HIPP. Please safely discard your application forms. If you are not sure you qualify, feel free to call our toll-free number to speak with a WV HIPP eligibility advisor at 1-855-MyWVHIPP (855-699-8447).**

4. Please complete this section with the policyholder's information.

Name of Policy Holder: _____

Address: _____

City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____ Email(Required): _____

❑ Yes, once email correspondence is available, it is okay to send important information about WV HIPP and my WV HIPP payments to my email address provided above. (Check box if this statement is true.)

SSN: _____ DOB: _____

Insurance Company: _____

Policy Number (Mandatory): _____ Group Number: _____

Effective Date of Policy: _____ End Date: _____ Other: _____

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FORM ONE (continued): West Virginia Health Insurance Premium Payment Application

5. List all persons covered by the policy who are eligible for Medicaid. (Use extra paper if you need to.)

Name	Social Security Number	Birth Date	Medicaid ID Number	Relationship to Policyholder	Gender	Condition
		/ /				
		/ /				
		/ /				
		/ /				

6. DIRECT DEPOSIT (Check box to sign up for Direct Deposit):

❏ If accepted into the WV HIPP program, I would like to participate in Direct Deposit, once this option is available. By doing so, WV HIPP will deposit my payments into my checking account and I will not receive a paper check. If I am not accepted into the program, WV HIPP will properly discard my banking information.

Bank Name: _____ Routing #: _____ Account #: _____

Checking account: Attach a copy of a voided check. Your voided check has your bank's routing number and bank account number; both are needed to send your payment by direct deposit.

7. From what source did you receive this application (choose an option below)?

❏ Mail	❏ County Caseworker	❏ Hospital	❏ Health related support group	❏ Other_____

You can either fax or mail a copy of this form back to the HIPP

program. Fax: 855-888-3003
Mailing address: WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

If you have any questions about this application, contact our office at our toll free number 1-855-MyWVHIPP (855-699-8447).

For faster processing, attach a copy of the front and back of your **insurance card, employer rate sheet** (if available), **summary of benefits**, and a recent **paystub or other verification** to show your premium payment.

Sincerely,

The HIPP Team

3501 MacCorkle Ave SE #201
Charleston, WV 25304

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FORM TWO: West Virginia Health Insurance Premium Payment Application

Private policyholders: Complete FORM ONE and return it to the WV HIPP program. You may discard FORM TWO.

Employer-sponsored policyholders: Complete FORM ONE and FORM TWO and return it to the WV HIPP program. FORM TWO should be completed by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator.

1. Has employment terminated for the employee listed above? ❑ YES, Date: _____ ❑ NO

2. Employer Information:

Employer Name: _____ Federal Tax ID (Mandatory): _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

How many full time individuals does your company currently employee? _____

3. Employer-sponsored health insurance information:

Do you offer insurance to your employees? ❑ YES ❑NO

If YES, please complete the rate table below.

*Please complete the table below using family plan rates for each health insurance plan offered OR attach your company rate sheet. Also, please provide a **Summary of Benefits** for the health insurance plan accessible to the applicant.*

	Carrier Name	Plan	Persons Covered	Monthly Employer Contribution	Monthly Employee Contribution	Group #
Individual						
Individual + Spouse						
Individual + Child						
Family						

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FORM TWO (continued): West Virginia Health Insurance Premium Payment Application

3. Employer-sponsored health insurance information (continued):

If you answered Yes to "Do you offer insurance to your employees?," does this individual have access to purchasing a family plan? ❑ YES ❑ NO

When does your company's open enrollment period start and end (If applicable)? _____

4. Employee's History:

Has the individual listed above withdrawn from a family health plan within the last six months? ❑ YES ❑ NO

If YES, which plan? _____ Plan Termination Date: _____

5. Your Information:

Name (Print): _____ Signature: _____

Your Title: _____ Date Signed: _____

Phone: _____ Ext: _____

You can either fax or mail a copy of this form back to the HIPP program.

Fax: 855-888-3003
Mailing address: WV HIPP
3501 MacCorkle Ave SE #201
Charleston, WV 25304

If you have any questions about this application form, contact our office at our toll free number 1-855-MyWVHIPP (855-699-8447).

Sincerely,

The HIPP Team