REQUEST FOR THE HEALTH INSURANCE BUY-IN (HIBI) PROGRAM OF COLORADO MEDICAID

The Health Insurance Buy-In (HIBI) program of Colorado Medicaid can pay health insurance premiums, deductibles, and coinsurance for a Medicaid client if the health insurance plan is likely to be cost-effective to Medicaid. The purpose of this program is to save taxpayer dollars while providing for the medical needs of Medicaid clients. HIBI is a service Medicaid offers in addition to your regular Medicaid benefits. **Please read the instructions on the back of this form.**

(YOU MUST ANSWER ALL QUESTIONS AND AN MS-10 FORM MUST BE ATTACHED.)

Name(s) of Medicaid Client(s) to be considered for HIBI:	State ID(s):
Address:	
Home Phone No.:	Daytime Phone No.:
Name of Health Insurance Plan to be Considered for HIBI: You must attach a copy of the MS-10 form for this health plan. (See other side for list of all other required documents.)	Member Name: Policy/Subscriber Number:

1. Has your health insurance ended within the last 60 days, or will it end within the next 60 days? YES NO
2. If yes, for what reason is the insurance coverage ending? _____
3. When is the next open enrollment period? _____
4. Is your health insurance coverage court-ordered (part of a divorce/separation decree)? YES NO
5. Is this a COBRA plan? YES NO If yes, what are the COBRA begin & end dates? _____
6. Do you have a disability trust or a pooled trust? _____
7. List any medical conditions for which you are being treated. _____
8. Are the health care providers you use able to bill both your insurance and Medicaid? YES NO
9. Are all the health care providers you use IN-NETWORK (for plans that have a network)? YES NO
10. Please complete the following information about how your premiums are paid (Check One):

☐ Payroll Deduction Name of Employee _____

☐ Check or Money Order sent to (Circle One): Insurance Company/Employer/COBRA Administrator

☐ OTHER (Explain): _____

11. What is your premium cost (What comes out of your pocket) and how often is it paid? Please fill out chart below, AND attach a Premium Rate Sheet from your employer or insurance representative. Please list ALL rates offered, not just the one you are paying.

COVERAGE	PREMIUM	HOW OFTEN?	PAYMENTS/YEAR	ANNUAL (STATE USE)
Employee/Self Only				
Employee + Spouse				
Employee + Child(ren)				
Employee + Family				

I authorize any person, medical provider, insurance company, or other organization to provide any information about me or my dependent's health insurance, medical treatment and employment to the Department of Health Care Policy & Financing upon request. (Copies of this form are legal.)

Signature	Date

INSTRUCTIONS FOR COMPLETING THIS FORM

Documents required for a completed HIBI application:

- A completed, signed, MS-10 form - Client Health Insurance Information (from your county department of social/human services)
- A completed signed, HIBI Request form (from your county department of social services)
- Copy of the front and back of your insurance card
- Copy of the premium rate sheet (from your employer or insurance representative)
- Copy of a Power of Attorney or Personal Representative Designation form, if anyone other than the client or policyholder signs the form

1) Please answer ALL questions AND attach a copy of the premium rate sheet showing ALL rates offered to you. Your request cannot be processed without complete information.

2) Write the name and subscriber number of the health insurance plan for which you are requesting HIBI.

3) Attach a copy of the MS-10 form for this health plan (this is required per HIPAA regulations). If you have already submitted an MS-10 for this plan, you can ask your county technician for a copy of the MS-10 in your case file. Then go to step 4.

4) Staple all attachments to the front of this form.

5) Fold the form so that the address below is visible. No envelope is needed.

6) Attach a first-class postage stamp in the upper right-hand corner and mail, or give to your county technician to mail for you. Or, you may fax it to 303-866-3552.

- fold here -

Stamp

MAIL TO:

Medicaid - HIBI Program
Benefits Coordination Section
1570 Grant Street, 4th Floor
Denver, CO 80203-1818

Staple or Tape