Reset Form

MEDICAL INSURANCE QUESTIONNAIRE
HEALTH INSURANCE PREMIUM PAYMENT PROGRAM (HIPP)

State Form 46771 (R3 / 10-11)

HP TPL Unit
P.O. Box 7262
Indianapolis, IN 46207-7262
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INSTRUCTIONS:
1. *Complete this form for members who have employer health insurance available to them. Do not complete if the insurance is available through an absent parent.*
2. *Mail or fax the completed questionnaire along with OMPP Form 3510 to the HP TPL Unit at the above address.*

NOTE: The HIPP program will pay for the cost of premiums to enroll Medicaid members in group health insurance that is available through their employer or, in certain situations, a household member's employer. If the Medicaid Program determines that enrollment in an employer health insurance plan is cost-effective to Medicaid, the member is required to enroll in the plan, and Medicaid will cover the individual's cost of the premiums. (The program will not pay for the employer share.)

Name of case	Case number

NAME OF MEMBER	RID NUMBER	NAME OF EMPLOYEE WHO HAS INSURANCE AVAILABLE	NAME OF EMPLOYER

Complete the information below for all members who have had any of the listed medical conditions in the last year.

CONDITION	NAME OF MEMBER	NAME OF PHYSICIAN	APPROXIMATE DATE OF ONSET *(month, day, year)*
1. Second or Third Degree Burns			
2. Head Injury			
3. Back Injury			
4. Severe Eye Injuries			
5. Pregnant With Multiple Babies			
6. Problems Related to Pregnancy			
7. Diabetes With Pregnancy			
8. Cancer			
9. Heart Attack			
10. Stroke			
11. Diabetes			
12. Lung Condition			
13. Bone Problems			
14. Debilitating Birth Defect			
15. Brain Tumor			
16. Liver Condition			
17. AIDS / HIV			
18. Other *(please explain)*:			