DPHHS-HCS-449M
(Rev. 06-19)

Case

STATE OF MONTANA
Department of Public Health and Human Services
Human & Community Services Division

HEALTH INSURANCE PREMIUM PAYMENT REFERRAL

Please complete the form and submit to the TPL Unit by fax at 406-444-1829 or by mail
DPHHS-TPL UNIT PO BOX 202953 HELENA, MT 59620-2953

The information on this form is used to determine if we may pay some or all of your health insurance premium. This may save money for both you and the Medicaid Program.

Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

1. **Health Insurance Policy Status** (Check one)
☐Current policy start date _____ ☐Policy end date _____
☐Policy ended on _____ ☐Insurance available through university/employer ***not enrolled***

2. **Policy is** (Check one)
☐an individual health plan ☐a student health plan ☐a group health plan
☐a COBRA continuation plan ☐from an absent parent

3. **Employer/University Who Offers Insurance:** _____
Address: _____
City, State, Zip: _____ Phone: _____

4. **Insurance Company Name:** _____
Address: _____
City, State, Zip: _____ Phone: _____
Group Number: _____ Policy Number: _____

5. **Premium Amount:** $_____ **Frequency** (choose one): Weekly, Bi-Weekly, Semi-Monthly, Monthly, Semester

6. **Deductible:** Individual $_____ Family $_____ Max Out of Pocket $_____

7. **Premiums are Paid:**
☐directly to insurance company ☐employer pays all for employee ☐absent parent pays premiums
☐payroll deduction ☐employer pays all for family ☐not enrolled yet
☐never paid

8. **Policyholder Name:** _____ Date of Birth: ___/___/___ SSN: ___-___-___
Address: _____
City, State, Zip: _____ Phone: _____

9. **List all persons who can be covered by this insurance:**

Name	Social Security Number	Birth Date	Currently Enrolled On Insurance
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No
			☐Yes ☐No

PLEASE TURN PAGE OVER AND COMPLETE OTHER SIDE OF THIS FORM

THIS SECTION MUST BE COMPLETED BY THE OFFICE OF PUBLIC ASSISTANCE

Case Name: _____ **Case #:** _____

11. Check the following list for you and your family. For each problem you check with yes, write the name of the person with the problem. Tell us about any health care that is needed. Please provide approximate monthly cost and/or indicate how often and what type of health care is required.

Conditions or Problem		Person's Name	Monthly Medical Care Needed / Monthly Cost
Diabetes	☐Yes ☐No		
Blood Disorder	☐Yes ☐No		
Cancer	☐Yes ☐No		
Mental Illness	☐Yes ☐No		
Pregnancy	☐Yes ☐No		Due Date:
Developmentally Delayed	☐Yes ☐No		
Heart Condition	☐Yes ☐No		
Ear Infections, Asthma or Respiratory Problems*	☐Yes ☐No		
*Tobacco/Nicotine Use	☐Yes ☐No		Type/Quantity:
Back Problems or Injury	☐Yes ☐No		
Stroke	☐Yes ☐No		
Head Injury	☐Yes ☐No		
Organ Transplant	☐Yes ☐No		
Seizure Disorder	☐Yes ☐No		
Alcoholism or Drug Addiction	☐Yes ☐No		
HIV Positive	☐Yes ☐No		
Handicapped Child	☐Yes ☐No		
Kidney or Liver Disorder	☐Yes ☐No		
Other Problems	☐Yes ☐No		
(list other problems you go to the doctor for)			

12. Are any of the conditions that you checked "Yes" excluded from coverage for this insurance? ☐Yes ☐No

If "Yes", list conditions not covered: _____

_____

13. Are any of the conditions that you checked "Yes" covered by any other third party such as workers compensation or accident insurance? ☐Yes ☐No

If "Yes", list conditions covered: _____

14. Are you covered by Medicare? ☐Yes ☐No

If "Yes", what is your Medicare number: _____

15. How many prescriptions are filled each month for your family? _____

List types of medications: _____

_____

Does this insurance cover the cost of prescriptions? ☐Yes ☐No ☐Partially Covered