Request for Health Insurance and Premium Assistance

INSTRUCTIONS

YOU MAY BE ELIGIBLE TO RECEIVE ASSISTANCE WITH PAYMENT OF HEALTH INSURANCE PREMIUMS. If you or your dependents are Medicaid eligible and currently enrolled in or eligible for employer based or employer sponsored Health Insurance, you or the policy holder may be eligible to receive help in paying the policy holder's cost of premiums. Please provide information about the other health insurance on this form and attach the required supporting documentation.

THIS FORM IS REQUIRED TO:

- Determine if Coverage you have Access to is eligible for Premium Reimbursement and requires enrollment, if not currently enrolled
- Request Premium Reimbursement for the First Time
- Request Continuation of Premium Reimbursement when Medicaid Eligibility Renews
- Notify Medicaid of a Change in Coverage or Premiums

YOU WILL NEED THE FOLLOWING SUPPORTING DOCUMENTATION:

- Completed and Signed Request for Health Insurance and Premium Assistance Information
- Copy of the Front and Back of each Card for which you currently have coverage
  - MEDICAL
  - PRESCRIPTION
  - DENTAL
  - VISION
- Proof of Premium being Paid for current coverage
  - Copy of a Current Paystub Showing Premium Deductions, or
  - Billing Statement and Record of Payment, or
  - Employer Section 3 of this form showing premium deduction if not payroll deducted or otherwise invoiced
- All Benefit Summary and Cost for Insurance Benefits for which you May be Eligible for, if not enrolled

HOW TO SUBMIT DOCUMENTATION TO NEW YORK STATE DEPARTMENT OF HEALTH:

You may submit the documentation in the following ways:

- Log into your account at www.nystateofhealth.ny.gov to upload documentation.
- Fax the documentation to 1-855-900-5557; or
- Mail the documentation to: New York State of Health
  PO Box 11727
  Albany, New York 12211

To help us identify the documents, please write "TPL", your First and Last Name, Date of Birth, your Marketplace ID, and Account ID on each document.

New York State of Health is unable to return documents sent for verification. Please send a copy of the original document and keep the original for your records.

If you have questions, you can call New York State of Health at: 1-855-355-5777 (TTY: 1-800-662-1220).

Request for Health Insurance and Premium Assistance

The information and documentation provided will be reviewed to determine if New York State Medicaid can pay all or some of the policy holder's share of the premiums. Please indicate if you are:

☐ **Requesting premium reimbursement**
☐ **Reporting a change/updating current information**
☐ **Providing information about coverage available through an employer, but not currently enrolled**

SECTION 1. This Section MUST be completed by the **NY State of Health Account Holder**.

______________________________ **AC** ______________________________
Name of Account Holder State of Health Account #

SECTION 2. This Section **MUST** be completed by the **Policy Holder** or **Individual with access to coverage** through an employer. By completing this Section and signing this form, you are attesting that what is provided is true. You are also authorizing NYS Medicaid to obtain all pertinent information from your employer, health insurance carrier and any other party relevant to the determination process regarding cost-effective Third-Party Health Insurance.

______________________________ ______________ ______________
Name of Policy Holder or individual with access to coverage Social Security Number Phone Number (Including area code)

______________________________ ______________ ________ ________
Mailing Address City State Zip Code

Relationship to NY State of Health Account Holder: ☐ Self ☐ Spouse/Domestic Partner ☐ Parent/Guardian ☐ Other: ______________

Individual is: ☐ Enrolled in coverage ☐ Eligible to enroll in coverage

Coverage Available Through: ☐ Employment ☐ Retirement ☐ COBRA ☐ Other: ______________

Premium(s) Paid by: ☐ Payroll Deduction ☐ Direct to Employer ☐ Other ______________

List ALL Covered Individuals who are active on the policy. (Add additional page(s) if necessary)

Name	Date of Birth	TPHI Coverages	Medicaid Eligible	Member Relationship
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	
		☐ Medical ☐ Prescription ☐ Dental ☐ Vision	☐ Yes ☐ No	

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Please provide a copy of the front and back of ALL cards for which you have coverage. If a card is not provided for dental or vision, please provide the following:

Dental Carrier Name: _____ **Policy Number:** _____

Vision Carrier Name: _____ **Policy Number:** _____

Policy Type enrolled in or available to employee:

☐ Individual ☐ Employee +1 ☐ Employee and Children ☐ Family ☐ Other _____

Employee is:

☐ Currently Enrolled in Coverage ☐ Eligible to enroll in coverage as of _____

AUTHORIZATION:

ANY CHANGES TO ENROLLMENT STATUS OR PREMIUM AMOUNTS MUST BE COMMUNICATED TO NYS MEDICAID AS SOON AS POSSIBLE. If the amount of the premium changes or someone is added or removed from the policy, or you lose or get new insurance, you must report this to New York State of Health immediately. If you do not report changes in a timely manner, **you may need to pay money back to Medicaid**.

By signing this request, you confirm that you understand, accept, and agree with the program limitations and conditions described above. In addition, you further agree to the release of all pertinent information by your employer, health insurance carrier and any other party relevant to the determination process regarding cost effective Third-Party Health Insurance. By signing below, you are attesting that the information provided on this request is true and accurate to the best of your knowledge.

State of Health Account Holder

_____ _____
Printed Name Date

_____
Signature

Policy Holder (if other than Account Holder)

_____ _____
Printed Name Date

_____
Signature

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SECTION 3. THIS SECTION MUST BE COMPLETED IF COVERAGE IS EMPLOYER RELATED

This Section MUST be completed by **Employer Representative** on behalf of the Employee/Policy Holder as indicated in Section 2. Pursuant to Social Services Law §143, all employers of any kind doing business within New York State are required to furnish to the social services official and the NY State of Health, information about employees including information regarding health insurance coverage. Failure to do so may result in court action and penalties.

Please attach additional documentation as needed including any scope of benefits or information relative to coverage available to an employee who has yet to enroll in coverage.

Employer/Company _____ FEIN or Tax ID _____ Phone Number (Including area code) _____

Mailing Address _____ City _____ State _____ Zip Code _____

Contact Person* _____ Phone Number* (Including area code) _____ Email* _____

Policy Type enrolled in or available to employee:

☐ Individual ☐ Employee +1 ☐ Employee and Children ☐ Family ☐ Other _____

Employee is: ☐ Currently Enrolled in Coverage ☐ Eligible to enroll in coverage as of _____

Plan year is from: _____ to _____

Premium Payment Information:

Coverage	Number of Premium Payments Annually	Premium Payment Deduction Amount Per Pay Period	Carrier Name	Policy Number	Number of Covered Individuals (include Employee)
Medical		$			
Prescription		$			
Dental		$			
Vision		$			

Deductible (In Network): Medical _____ / _____ (Individual/Family) Dental _____ / _____ (Individual/Family)

Please sign below to attest that the information provided is true and accurate to the best of your knowledge.

Employer Representative

Printed Name _____ Date _____

Signature _____

Please write your First and Last Name, Date of Birth, your Marketplace ID, and Account ID on each document. You may submit documentation in the following ways:

Log into your State of Health Account at www.nystateofhealth.ny.gov to upload documentation.	**Fax the documentation to:** 1-855-900-5557	**Mail the documentation to:** New York State of Health P.O. Box 11727 Albany, NY 12211	**For questions, call:** 1-855-355-5777 (TTY: 1-800-662-1220)