

Dear Applicant,

The Colorado Health Insurance Buy-In (HIBI) Program may reimburse health insurance premiums for a Medicaid client if the cost of the health insurance plan is cost-effective to Medicaid. The purpose of this program is to provide for the medical needs of Medicaid clients and to save taxpayer dollars. HIBI is a service Medicaid offers in addition to your regular Medicaid benefits.

To be eligible for HIBI, your application must show that you or a member of your family are eligible for Medicaid during the time period for which payments are requested and must be covered by, or have access to, a cost-effective group or individual health insurance plan.

To apply for the Colorado HIBI program, fill out the attached application and return it with all the required documents listed below:

- **Premium rate sheet from your employer or insurance representative**
- **Summary of benefits (including deductible and co-insurance rates)**
- **Copy of the front and back of your insurance card (if you are already enrolled)**
- **Recent paystub or other verification of premium payment (if you are already enrolled)**

Fax or mail your application and documents within 10 days of the date of this letter to the address below.

If you buy health insurance through your employer: Complete Form One and Form Two and return them to the Colorado HIBI Program within 10 days. Form Two may be completed by the health insurance member's employer, such as a human resource representative or benefits coordinator. Include both the employer and employee contributions for all premium tiers.

If you do not buy health insurance through your employer: Complete Form One and return it to the Colorado HIBI program within 10 days along with the required documents above.

Fax: (855) 226-4424
Mailing Address: Colorado HIBI Program
5615 High Point Dr.
Irving, TX 75038

Sincerely,
Your HIBI Team

Health Insurance Buy-In (HIBI) Application: Form One

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

IF YES, which type: Employer COBRA Other

What is the premium for this policy? \$ _____

These premiums are paid/ deducted:

Weekly Biweekly Semi-Monthly Monthly Quarterly Other

Type of Coverage:

Individual Individual and Child(ren) Individual and Spouse Family

IF NO, do you have access to health insurance, such as insurance benefits through your job? Yes No

3. Is your health insurance coverage court-ordered (part of a divorce/separation decree)? Yes No

4. Are your current providers in network? Yes No

If you do not have access to health insurance, you are not eligible for the Colorado HIBI program. Please safely discard your application forms. If you are not sure whether you are eligible, please call our toll-free number to speak with a Colorado HIBI eligibility advisor at (855) MyCOHIBI or (855) 692-6442.

Please complete this section with the policyholder's information and signature.

Name of Member: _____ SSN: _____ DOB: _____

Address: _____

City/ State/ Zip: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Health Insurance Buy-In (HIBI) Application: Form One (cont'd)

Insurance Company Name: _____

Policy/Subscriber/Member Number: _____

Group Number: _____

Dental Insurance Company Name (if applicable): _____

Effective Date of Policy: _____ End Date: _____

List everyone in your household covered by your policy, including Medicaid recipients. (Use extra paper if necessary.)

Name	Social Security Number (Last 4 digits)	Birth Date	Medicaid ID Number	Relationship to Member	Gender	Medical Condition (e.g. Diabetes, HIV, etc.)

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 and Financing and its Business Associates upon request.

Signature: _____ Date: _____

To process your application and provide premium reimbursement, the Colorado HIBI program must receive a copy of the front and back of your insurance card, the premium rate sheet, summary of benefits, and a recent paystub or other verification to show proof of your premium payment.

Phone: (855) MyCOHIBI or (855) 692-6442 | Monday to Friday, 8 a.m. to 5 p.m. Mountain Standard Time
Fax: (855) 226-4424 | Website: www.MyCOHIBI.com | Email: MyCOHIBICustomerService@GainwellTechnologies.com

Health Insurance Buy-In (HIBI) Application: Form One (cont'd)

Please provide the following information in order to facilitate direct deposit reimbursement of your premium if your application is accepted.

Bank Name: _____

Name on Bank Account: _____

Account #: _____

Routing #: _____

Attach a copy of a voided check below:

Please fax or mail a copy of this form to the Colorado HIBI program.

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Irving, TX 75038

If you have any questions about this application, contact our office at our toll-free number: (855) 692-6442.

Health Insurance Buy-In (HIBI) Application: Form Two

Only complete Form Two **if you purchase health insurance through your employer**. You may complete this yourself or provide it to your employer or human resources department for completion.

1. Name of Applicant: _____

2. Employer Name: _____ Employer Federal Tax ID: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer Phone Number: _____ Fax Number: _____

3. Employer-sponsored health insurance information:

Does your company offer health insurance to employees: Yes No

If YES, please attach your company rate sheet showing all rates offered. Also, please provide a Summary of Benefits that includes deductibles and co-insurance amounts for the health insurance plan accessible to the applicant.

4. When is your company's open enrollment period? Start: ____/____/____ End: ____/____/____

5. Company Contact Information (e.g. human resources representative; benefits coordinator):

Name (Print): _____ Signature: _____

Title: _____ Date Signed: _____

Phone: _____ Ext: _____

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