FLHIPP
820 S. MacArthur Blvd, Suite 105-340
Coppell, TX 75019

Dear Member,

Health Management Systems, Inc. (HMS) is the authorized contract representative for the Florida Health Insurance Premium Payment (FLHIPP) Program. The FLHIPP Program was developed to help qualified individuals enrolled in Medicaid, pay for health insurance offered through an employer.

You are receiving this letter because of recent changes that were made to Florida law. These changes may require Florida Medicaid recipients who have access to health insurance through an employer to enroll in that insurance plan if it is determined to be cost effective for the State of Florida. "Cost-effective" means that it costs the State less to pay your health insurance premium than for Medicaid to pay all of your medical costs directly. Recipients enrolled in the FLHIPP Program will not participate in the Statewide Medicaid Managed Care program.

If you qualify for the program, FLHIPP will reimburse you for the employee's portion of your insurance premium. The premium is your monthly cost for health insurance coverage.

Included with this letter you will find the FLHIPP application form. To comply with Florida law, fill out the attached application and either fax or mail it back to us in the enclosed postage-paid envelope within 30 days. For faster processing, we ask that you please follow all instructions while completing your application.

Fax:	844-449-3450
Address:	820 S. MacArthur Blvd, Suite 105-340 Coppell, Texas 75019

The FLHIPP Program is a way for the State of Florida to save money while providing Floridians access to quality healthcare. If you choose not to give us the information we need to determine your eligibility for the FLHIPP Program, your Medicaid benefits may be stopped. If you have any questions, please contact the FLHIPP program at our toll-free phone number 877-357-3268.

Sincerely,

The FLHIPP Team

FLHIPP
820 S. MacArthur Blvd, Suite 105-340
Coppell, TX 75019

Florida Health Insurance Premium Payment Application Form One

FORM #1 is to be filled out by the APPLICANT. FORM #2 should be filled out by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator at your job.

1. Do you or anyone in your family receive Medicaid Benefits? ❑ YES ❑ NO

2. Do you or anyone in your family have health insurance through an employer? ❑ YES ❑ NO

2a. If YES,

what is the premium for this health insurance policy (if known)? $_____ These premiums are paid/deducted:

❑ Weekly	❑ Biweekly	❑ Semimonthly	❑ Monthly	❑ Quarterly	❑ Other

Type of Coverage: ❑ Individual ❑ Individual and child ❑ Individual and Spouse ❑ Family

2b. If NO, can you or anyone in your family get insurance through an employer? ❑ YES ❑ NO

2c. If YES to 2b, tell us as much as you can about the healthcare plan you have access to as well as information about the employer providing the plan in questions 3 to 4. **If you answered no to 2b, and do not have any way of obtaining employer-sponsored insurance, please stop at this point and return this form only.**

3. Please complete this section with the policyholder's information. If you do not have access to health insurance, please skip to form #2.

Name of Policy Holder: _____

Address: _____

City/ State/ Zip: _____

Home Phone:_____ Cell Phone:_____ Email: _____

❑ Yes, it is okay to send important information about FLHIPP and my FLHIPP payments to my email address provided above. (Check box if this statement is accurate.)

SSN:_____ DOB: _____

Insurance Company: _____

Policy Number:_____ Group Number: _____

Effective Date of Policy:_____ End Date:_____ Other: _____

Florida Health Insurance Premium Payment Application Form One (continued)

4. List all persons covered by the policy who are eligible for Medicaid. (Use extra paper if you need to.)

Name	Social Security Number	Birth Date	Medicaid ID Number	Relationship to Policyholder	Gender
		/ /			
		/ /			
		/ /			
		/ /			

5. **DIRECT DEPOSIT** (Check box to sign up for Direct Deposit): ❑ If accepted onto the FLHIPP program, I would like to participate in Direct Deposit. By doing so, FLHIPP will deposit my payments into my checking or savings account and I will not receive a paper check. If I am not accepted into the program, FLHIPP will properly discard my banking information.

Bank Name:_____ Routing #:_____ Account #: _____
Type of Account (Please check one): ❑ Checking ❑ Savings

Checking account: Please do not forget to attach a copy of your voided check. Your voided check has your bank's routing number and bank account number; both are needed to send your payment by direct deposit.

Savings account: Your bank account number and ABA routing numbers are needed. You may contact your bank if you do not know these numbers.

If you have any questions about this application, contact the FLHIPP office at our toll free number 877-357-3268.

For faster processing, attach a copy of the front and back of your **insurance card,** if you have one, **employer rate sheet, summary of benefits,** and a recent **paystub or other verification** to show your premium payment. If you have any questions, call our toll free number 877-357-3268.

FLHIPP
820 S. MacArthur Blvd, Suite 105-340
Coppell, TX 75019

Florida Health Insurance Premium Payment Application Form Two

FORM #2 should be filled out by the policyholder's EMPLOYER, such as a Human Resource representative or Benefits Coordinator. This form is to be completed on behalf of the FLHIPP applicant that has selected "Employer" as their type of healthcare policy plan.

1. Has employment terminated for the employee listed above? ❑ YES, Date:_____ ❑ NO

2. Employer Information:

Employer Name:_____ Federal Tax ID **(Mandatory):** _____

Address:_____ City:_____ State:_____ Zip: _____

Phone Number:_____ Fax Number: _____

How many full time individuals does your company currently employ? _____

3. Employer-sponsored health insurance information:

Do you offer health insurance to your employees and their dependents? ❑ YES ❑ NO

If YES, when is your company's open enrollment period (If applicable)? _____

Please complete the table below OR attach your company rate sheet. Also, please provide a ***Summary of Benefits*** *for the health insurance plan accessible to the applicant.*

	Carrier Name	**Plan**	**Persons Covered**	**Monthly Employer Contribution**	**Monthly Employee Contribution**	**Group #**
Individual						
Individual + Spouse						
Individual + Child						
Family						

Florida Health Insurance Premium Payment Application Form Two (continued)

3. Employer-sponsored health insurance information (continued):

If you answered No to "Do you offer insurance to your employees and their dependents?" stop here and return this form.

4. Applicant's History:

Has the individual listed above withdrawn from a family health plan within the last six months? ❑ YES ❑ NO

If YES, which plan?_____ Plan Termination Date: _____

5. Your Information:

Name (Print):_____ Signature: _____

Your Title:_____ Date Signed: _____

Phone:_____ Ext: _____

If you have any questions about this application, contact our office at our toll free number 877-357-3268.

You can either fax or mail a copy of this form back to the FLHIPP program.

Fax: 844-449-3450
Mailing Address: FLHIPP
820 S. MacArthur Blvd, Suite 105-340
Coppell, Texas 75019