Health First COLORADO
Colorado's Medicaid Program

Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

DATE

Case Number :
PIER ID :

POLICYHOLDER NAME
MAILING ADDRESS
CITY, ST ZIP

Dear POLICYHOLDER NAME,

The Colorado Health Insurance Buy-In (HIBI) program is currently reevaluating your eligibility to participate in the program. **You are required to update your information every year** to ensure that we have the most recent information about your health insurance coverage and confirm that you continue to remain eligible for the Colorado HIBI program.

Please complete the information on the following page and return the signed form along with the requested documents by mail or fax to the address or fax number below.

Please indicate if your health insurance company, your policy number or your group number has changed.

Please complete the appropriate forms and supply the requested documents as soon as possible to prevent disruption to your HIBI benefits. If we do not receive the requested documents prior to the requested plan year, it may result in a delay or loss of HIBI payment.

Fax: 855-226-4424
Mail: Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

Sincerely,

Your HIBI Team

Health First COLORADO
Colorado's Medicaid Program

Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

DATE
POLICYHOLDER NAME
MAILING ADDRESS
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Colorado Health Insurance Buy-In (HIBI) Renewal

1. Health Insurance Company Name: _____
   Policy Number: _____ Group Number: _____
   Has your Health Insurance Company changed? ❑Yes ❑No Effective Date: _____
   Is this a new Policy Number? ❑Yes ❑No Effective Date: _____
   Is this a new Group Number? ❑Yes ❑No Effective Date: _____
   Dental Insurance Company Name (if applicable): _____
2. Are you adding or dropping any dependents from your insurance plan? ❑Yes ❑No
   If Yes, please complete the following:

Dependent Name	Date of Birth	Medicaid ID (if applicable)	Relationship to Member	Added/Dropped Members	Chronic Medical Condition(s)

3. My current providers are in-network. ❑Yes ❑No
4. Please provide a copy of:
   a. Your insurance card.
   b. Rate information for your upcoming plan year for all coverage levels (employee/individual only; employee/individual + spouse; employee/individual + child(ren); and family). Your human resources department or insurance broker should be able to provide this information.
   c. Summary of Benefits for your health insurance for the upcoming year (including deductible and coinsurance amounts).
5. Verification of your plan rate change must be received **within 30 days of your new policy effective date** (e.g., paystub, cleared check to the insurance carrier, bank statement showing payment).

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:** _____

Phone #: _____ **Email Address:** _____

Remember to report any changes to your email, phone number, address, employment, or insurance coverage to the Colorado HIBI Customer Service Team. Failure to do so may delay payment of your premiums.
855-MyCOHIBI (855-692-6442) | MyCOHIPPCustomerService@GainwellTechnologies.com