Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

DATE

POLICY HOLDER NAME
MAILING ADDRESS
CITY, ST. ZIP

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

Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

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: _____

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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.

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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.

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

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

Health First COLORADO
Colorado's Medicaid Program

Colorado HIBI Program
5615 High Point Dr
Irving, TX 75038

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: _____

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

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Mailing Address:	Colorado HIBI Program 5615 High Point Dr Irving, TX 75038

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